

1004

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 FilmG254 1-18-60 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTY

Prince Georges

MARYLAND

## b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

## c. LENGTH OF STAY IN 1b

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

## b. COUNTY

Anne Arundel

## c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Davidsonville

02X-2

## d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

DOA Prince George General Hosp.

## d. STREET ADDRESS

Post Office

e. IS RESIDENCE  
ON A FARM?  
YES ☒ NO ☐3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

RICHARD

JAMES

ABRIMS

4. DATE  
OF  
DEATH

Month

Day

Year

January 10,

19 60.

## 5. SEX

Male

## 6. COLOR OR RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

## 8. DATE OF BIRTH

April 14, 1935

9. AGE (in years  
last birthday)

24 yrs.

## IF UNDER 1 YEAR

Months Days Hours Min.

## IF UNDER 24 HRS.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

## 10b. KIND OF BUSINESS OR INDUSTRY

General Labor

## 11. BIRTHPLACE (State or foreign country)

Davidsonville, Md.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Issiah Abrims

## 14. MOTHER'S MAIDEN NAME

Madeline Rollins

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

Yes

None

16. SOCIAL SECURITY NO.  
(If yes, give war or dates of service)217 323254  
unknown

## 17. INFORMANT

Address

Mr. Issiah Abrims, Davidsonville, Md.

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Hemorrhage and Shock

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

Fractured Base of Skull crushed chest  
and abdome.

DUE TO

(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN  
ONSET AND DEATH19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Driver of Auto collided with fixed object (culvert).

## 20c. TIME OF INJURY

Month, Day, Year

Hour  
3:10 p.m.  
1/10/ 19 60

## 20d. INJURY OCCURRED

While  
at work ☐ Not while  
at work ☒20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

Central Ave.

## 20f. (City or town)

Seat Pleasant, Prin. Geo. Cty

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

January 10, 1960

EXAMINER'S  
NAME (Type)

JAMES I. BOYD, M.D.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

1/13/60

## 22c. NAME OF CEMETERY OR CREMATORY

UNION METHODIST

## 22d. LOCATION (City, town, or county)

DAVIDSONVILLE MD

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

Frederick Hardisty

## ADDRESS

Calverly Md

## 24a. REC'D BY REGISTRAR

JAN 13 '60

## 24b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

**THE UNIVERSITY OF CHICAGO**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1023 CERTIFICATE OF DEATH

00987

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville - Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paint Branch Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Josephine Bailey</u>		4. DATE OF DEATH Month Day Year <u>1 14 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1866</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scamstrasse (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PULMAN CO. Wash. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Kennedy</u>		14. MOTHER'S MAIDEN NAME <u>Bridgette Francis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, bronchial, bilateral</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized debility, arteriosclerotic</u> DUE TO (c) <u>heart disease</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>a few years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1959</u> to <u>Jan 14, 1960</u> , that I last saw the deceased alive on <u>Jan 14, 1960</u> , and that death occurred at <u>8 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest E. Harman</u> M.D.		ADDRESS (Street, city or town, state) <u>9301 COLEVILLE RD</u>	
PHYSICIAN'S NAME (Type) <u>ERNEST E. HARMAN</u>		DATE SIGNED <u>1/14/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/18/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. CLEMENS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS JR.</u>		ADDRESS <u>517-11 ST SE. WASH. D.C.</u>	
24a. REC'D BY REGISTRAR <u>Jan 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1098 J. Li et al.



## CERTIFICATE OF DEATH

Reg. Dist. No.

00988

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>7 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville 61</b> d. STREET ADDRESS <b>3611 Jefferson St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Minnie E. Baker</b>		4. DATE OF DEATH Month Day Year <b>Jan. 2 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-2-80</b>
9. AGE (In years lost birthday) <b>79 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>ILL.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE CHAPMAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY E TRYON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>LUELLE B SMITH</b>		Address <b>3611 Jefferson St Hyattsville Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>coronary artery disease and left branch occlusion</b> DUE TO (c) <b>arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 26, 1959</b> to <b>Jan. 2, 1960</b> , that I last saw the deceased alive on <b>Jan 2, 1960</b> , and that death occurred at <b>11:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>T. B. Bergeon</b>		ADDRESS (Street, city or town, state) <b>9314 Jallott St Hyattsville</b>	
PHYSICIAN'S NAME (Type) <b>May Lane</b>		DATE SIGNED <b>Jan 7 '60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>SHIP RR</b>	22b. DATE THEREOF <b>1-3-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>St Paul Nebraska</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>		24. REG'D BY REGISTRAR <b>5801 Cleveland Ave</b> DATE <b>JAN 7 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kras</b>			

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. This certificate may be filled in by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]  
11. Date of registration: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00989

Reg. Dist. No.

1084

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Spring</b>			c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland 20</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Andrews USAF</b>				d. STREET ADDRESS <b>4329 Huron Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eugene</b> First <b>Wendell</b> Middle <b>Baughan</b> Last				4. DATE OF DEATH <b>Jan.</b> Month <b>24</b> Day <b>1960</b> Year			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1959</b>		9. AGE (In years last birthday) yrs. <b>10</b> Months <b>18</b> Days <b>18</b> Hours <b>18</b> Min.	IF UNDER 1 YEAR Months <b>10</b> Days <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>No</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Eugene T. Baughan</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy Wendell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Mother</b> <b>Dorothy W. Baughan</b> Address <b>4329 Huron Ave. Suitland Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute pneumonia</b> <b>492x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James I. Boyd</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>January 24, 1960.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 27, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO.</b>				24a. REC'D BY REGISTRAR <b>JAN 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

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9VVVVVVVVVV

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CASE NO. <span style="float: right;">100-100000</span>	
DECEASED'S NAME <span style="float: right;">JOHN DOE</span>	DATE OF DEATH <span style="float: right;">JAN 15 1950</span>
PLACE OF DEATH <span style="float: right;">HOME</span>	CITY <span style="float: right;">BALTIMORE</span>
STREET <span style="float: right;">1234 E. MAIN ST.</span>	COUNTY <span style="float: right;">BALTIMORE</span>
DECEASED'S AGE <span style="float: right;">45</span>	
SEX <span style="float: right;">MALE</span>	
OCCUPATION <span style="float: right;">CLERK</span>	
MARITAL STATUS <span style="float: right;">MARRIED</span>	
CAUSE OF DEATH <span style="float: right;">HEART DISEASE</span>	
MANNER OF DEATH <span style="float: right;">NATURAL</span>	
SIGNATURE OF EXAMINER <span style="float: right;">[Signature]</span>	
TITLE OF EXAMINER <span style="float: right;">MEDICAL EXAMINER</span>	
DATE OF EXAMINATION <span style="float: right;">JAN 15 1950</span>	
PLACE OF EXAMINATION <span style="float: right;">HOME</span>	
CITY <span style="float: right;">BALTIMORE</span>	
COUNTY <span style="float: right;">BALTIMORE</span>	
STATE <span style="float: right;">MARYLAND</span>	

1085

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges'</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL-Upper Marlboro</b>		c. LENGTH OF STAY IN 1b <b>39 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Clagett Landing Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>F. X.</b> Last <b>Beall</b>		4. DATE OF DEATH Month <b>January</b> Day <b>26,</b> Year <b>1960.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Richard Wesley Beall</b>		14. MOTHER'S MAIDEN NAME <b>Tobitha Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mrs. Olive Catherine Beall-</b>		Address <b>same as above.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arteriosclerosis CV disease</b> DUE TO <b>8 yrs</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 hrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>55</b> , to <b>26 Jan</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>26 Jan</b> , 19 <b>60</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Upper Marlboro, Maryland:</b> DATE SIGNED <b>1/26/60</b> ACTUAL SIGNATURE <b>Robert B. Sasscer</b> M.D. PHYSICIAN'S NAME (Type) <b>Robert B. Sasscer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/29/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home-Marlboro, Md</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 2 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00991

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 13X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS Leishear Rd.	
3. NAME OF DECEASED (Type or print) Baby Girl		4. DATE OF DEATH Jan. 30 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1960
9. AGE (In years last birthday) 7		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gilbert W. Beckdardt		14. MOTHER'S NAME Doris Greenfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Mother Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x DUE TO <i>prematurely</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 23, 1960 to Jan 30, 1960 that I last saw the deceased alive on Jan. 30, 1960, and that death occurred at 5P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John R Buell</i>		ADDRESS (Street, city or town, state) 402 Main St., Laurel, Maryland	
PHYSICIAN'S NAME (Type) JOHN R BUELL		DATE SIGNED 2/1/60	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Feb 2-1960	22c. NAME OF CEMETERY OR CREMATORY New Calverton	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Donaldson</i>		ADDRESS <i>Laurel Md</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Charles E. Kneiss</i>	
DATE FEB 8 '60			



## 1007 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>p.</b> Last <b>Behan</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/27/1874</b>
9. AGE (In years lost birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labourer N.Y. State City, Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Queen's County, Ireland</b>	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Behan</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Scully</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes N.Y. #1</b>		16. SOCIAL SECURITY NO. <b>055-12-3438</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CURE BRAIN ARTERY THROMBOSIS</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS, Generalized</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>96 hours</b> <b>20 years</b>		18. INTERVAL BETWEEN ONSET AND DEATH <b>96 hours</b> <b>20 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 3, 1959</b> , to <b>Jan. 13, 1960</b> , that I last saw the deceased alive on <b>Jan 13, 1960</b> , and that death occurred at <b>10:55 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles D. Connor</b>		DATE SIGNED <b>4410 - 74TH AVE. BELLEMEAD</b>	
PHYSICIAN'S NAME (Type) <b>Charles D. Connor</b>		<b>Hyattsville, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/15/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va</b>
23. BURIAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home Mt. Rainier, Inc.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 15 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>			

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STATE OF MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

AGE

SEX

EDUCATION

PLACE OF BIRTH

PLACE OF DEATH

DATE

TIME

CAUSE OF DEATH

DIAGNOSIS

DATE OF DEATH

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## 1086 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 21 D.C.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5207 28th PARKWAY</u>		d. STREET ADDRESS <u>2629 30th ST. S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>ELVA</u> Middle <u>ELIZABETH</u> Last <u>BEHRENS</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 1, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>11</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TREASURY DEPT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOV.</u>	11. BIRTHPLACE (State or foreign country) <u>PHILA. PA.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>ARTHUR F. DAVIS</u>	
14. MOTHER'S MAIDEN NAME <u>ELVA L. BIRCH</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>MRS. MILDRED RHODES</u> Address <u>5207 28th PARKWAY HILLCREST ESTATES</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circumstances of Review</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastases to pleura and lungs.</u> DUE TO <u>lungs.</u> (c) <u>lungs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-26-1959</u> to <u>1-11-1960</u> that I last saw the deceased alive on <u>1-11-1960</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5731 23rd Parkway, SE 1-11-60</u> DATE SIGNED <u>Woods 21, D.C.</u>			
ACTUAL SIGNATURE <u>David S. Gordon</u> M.D.		PHYSICIAN'S NAME (Type) <u>Woods 21, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1/14/60</u>	<u>Fort Lincoln</u>	<u>Madisonburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		ADDRESS <u>309 4th St. S.E. Wash. D.C.</u>	24a. REC'D BY REGISTRAR DATE <u>JAN 13 '60</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1087  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b> c. LENGTH OF STAY IN 1b <b>3 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47x-3</b> d. STREET ADDRESS <b>3605 Van Ness St., N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Russell B. Behson</b>		4. DATE OF DEATH Month Day Year <b>1 14 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1/21/96</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>- - - -</b>	11. IF UNDER 24 HRS. <b>- - - -</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Examiner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Patent Office</b>	
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Benson</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Peterson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>Naval Academy</b> <b>1917 - 1917</b>		16. SOCIAL SECURITY NO. <b>-</b>	
INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> <b>002x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>myocardial infarction, old; cor pulmonale with congestive failure; pulmonary fibrosis and emphysema.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>40 years</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/11/</b> 1960, to <b>1/14/</b> 1960, that I last saw the deceased alive on <b>1/14/</b> 1960, and that death occurred at <b>7:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Glenn Dale Hospital</b> <b>1/14/60</b>			
ACTUAL SIGNATURE <b>Moe Weiss</b>		M.D. <b>Glenn Dale Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		<b>Glenn Dale, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1/16/60</b>	22b. DATE THEREOF <b>1/16/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges Cty, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Hines</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>	
ADDRESS <b>2901-14th St N.W. Wash. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

STATE OF DEATH

1902

NAME OF DECEASED

DATE OF DEATH

AGE

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF WITNESS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1065 CERTIFICATE OF DEATH

Reg. Dist. No. 00995

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Laurel General Hospital</b>		d. STREET ADDRESS <b>605 Fairlawn Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Florence Eugenia Besley</b>		4. DATE OF DEATH Month Day Year <b>January 19 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1873</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Baithlamew Besley</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Lung</b> DUE TO (c) <b>Gen'l Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 yr.</b> <b>10 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/2</b> , 19 <b>59</b> to <b>1/19/</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/18/60</b> , 19 <b>60</b> , and that death occurred at <b>3 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>J M Warren</b> M.D.			
PHYSICIAN'S NAME (Type) <b>John M. Warren, M.D. 305 Prince George Street, Laurel, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Cremation</b>	<b>1/21/60</b>	<b>St. Lincolns Cemetery</b>	<b>Calver Manor Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>De Witt Sanderson, Laurel, Md</b>		24a. REC'D BY REGISTRAR <b>JAN 22 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hirsch</b>	





CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLSIDE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLSIDE</u>			
c. LENGTH OF STAY IN 1b <u>23 YRS</u>				d. STREET ADDRESS <u>1206 52ND AVE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROBERT LEE BICKERS</u>				4. DATE OF DEATH <u>January 14 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 14 - 1931</u>	
9. AGE (In years last birthday) <u>28</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEVER WORKED</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES W. BICKERS</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE K. FOLK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS FLORENCE WILSON</u>		Address <u>1206 52 AVE. HILLSIDE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Acute cardiac insufficiency</u> DUE TO (b) <u>Hypertensive cardiovascular disease.</u> DUE TO (c) <u>Microcephalic.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>19</u> Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-14 - 1960</u> to <u>1-14 - 1960</u> , that I last saw the deceased alive on <u>1-14 - 1960</u> , and that death occurred at <u>3:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter Dulis</u>				ADDRESS (Street, city or town, state) <u>6134 Central Ave</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>PETER DULIS</u>				<u>Capitol Heights Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers Esq</u> ADDRESS <u>517 N E St SE</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Hump</u>		24b. REGISTRAR'S SIGNATURE	
				DATE <u>JAN 21 '60</u>			

Medical Exam. Dr. Boyd asked and approved

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## 1089 CERTIFICATE OF DEATH

Reg. Dist. No.

00997

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>4 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>WASHINGTON, D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b> d. STREET ADDRESS <b>4238 4th Street, SE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JANICE</b> Middle <b>GAIL</b> Last <b>BLAND</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 JANUARY 1960</b>
9. AGE (In years lost birthday) yrs. <b>4</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>WILLIAM R. BLAND</b>		14. MOTHER'S MAIDEN NAME <b>ANITA C CAVANAUGH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 Asphyxia</b> DUE TO <b>Remotely</b> Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>30 MINUTES</b> <b>4 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hyperbilirubinemia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 Jan</b> , 19 <b>60</b> , to <b>7 Jan</b> , 19 <b>60</b> , that I lost saw the deceased alive on <b>7 JAN</b> , 19 <b>60</b> , and that death occurred at <b>1753P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>ANDREWS AIR FORCE BASE</b> DATE SIGNED <b>7 JANUARY 60</b>			
ACTUAL SIGNATURE <b>John A Moore</b>		M.D. <b>ANDREWS AIR FORCE BASE</b>	
PHYSICIAN'S NAME (Type) <b>JOHN A MOORE, CAPT, USAF, MC</b>		USAF HOSPITAL ANDREWS, WASHINGTON 25, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/12/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) <b>ARLINGTON VA.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>RINALDI FUNERAL HOME</b>		ADDRESS <b>816 H St NE DC 2</b>	
24a. REC'D BY REGISTRAR <b>JAN 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knead</b>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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CERTIFICATE OF DEATH

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## 1008 CERTIFICATE OF DEATH

Reg. Dist. No. 00998

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>2 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Goldie</b>				4. DATE OF DEATH <b>Jan 27</b> 19 <b>60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 21, 1894</b>	
9. AGE (In years less birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>John W. Abbrose</b>				14. MOTHER'S MAIDEN NAME <b>Minnie E Harris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214 10 2930</b>		INFORMANT <b>Harvey E Boone</b>		Address <b>College Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>527.1</b> <b>Right heart failure</b> DUE TO (b) <b>Pulmonary embolism</b> DUE TO (c) <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>2. Atherosclerosis heart disease multiple bloody gastric ulcers</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 1957</b> to <b>Jan 27 1960</b> that I last saw the deceased alive on <b>Jan. 27 1960</b> , and that death occurred at <b>9:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. Til Bergman, M.D.</b>				ADDRESS (Street, city or town, state) <b>4314 Jello Rd Hyattsville, Md.</b>			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 1 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## 1090 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>Laurens</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Winchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>83x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Point Branch Nursing Home</u>		d. STREET ADDRESS <u>19 W Bond St.</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel Brittain Bowman</u>		4. DATE OF DEATH <u>Jan. 1 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>25</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal</u>	
11. BIRTHPLACE (State or foreign country) <u>TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cecelius B. Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Binyon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>338-05-9081</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe generalized arteriosclerosis</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral concussion and fracture of right lower leg, hit by automobile</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 24, 1959</u> , to <u>1-1-1960</u> , that I last saw the deceased alive on <u>12-24, 1959</u> , and that death occurred at <u>1:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. H. Philpott</u>		ADDRESS (Street, city or town, state) <u>6480 New Hampshire Ave. Takoma Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>William Howard Philpott</u>		DATE SIGNED <u>1-1-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-4-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shenandoah Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick County, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 5 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See the 1st

London

DECEASED

Baltimore

TENN.

Sheet 1st

1st

21-07-2001

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1091 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Croom</b>			c. LENGTH OF STAY IN 1b <b>10 yrs.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>08 Croom</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Croom Road</b>				d. STREET ADDRESS <b>1 Croom Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Lewis</b> Middle <b>E.</b> Last <b>Branson</b>				4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>19 60</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 23, 1885</b>		
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>74</b> Days <b>00</b> Hours <b>00</b> Min. <b>00</b>		IF UNDER 24 HRS. Months <b>00</b> Days <b>00</b> Hours <b>00</b> Min. <b>00</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George W. Branson</b>				14. MOTHER'S MAIDEN NAME <b>Mary Craig</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>- -</b>		17. INFORMANT <b>Mary V. Branson -Star Rt., Upper</b>				
Address <b>Marlboro, Md.</b>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> DUE TO (c)</p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Notural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>James I. Boyd, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>James I. Boyd, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home</b>				ADDRESS <b>Upper Marlboro, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 19 '60</b>		
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01001

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>HYATTSVILLE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>16 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5504 38th Avenue</b>				d. STREET ADDRESS <b>5504 38th Avenue</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alice Patricia Bratt</b>				4. DATE OF DEATH Month Day Year <b>Jan. 6, 19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-29-32</b>		9. AGE (In years last birthday) <b>27 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Leonard Bratt</b>				14. MOTHER'S MAIDEN NAME <b>Alice Fletcher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>No.</b>		17. INFORMANT Address <b>James Bratt; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b></p> <p><b>979X</b> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Smothering</b></p> <p>DUE TO (c)</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased apparently wrapped a plastic bag on her head.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>Jan. 5 or 6 19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hyattsville Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/8/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				24a. REC'D BY REGISTRAR <b>JAN 8 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Charles E. Kiana</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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3. *Conclusions*

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>74 Beltsville, Md.</b>		d. STREET ADDRESS <b>11714 Ellington Dr.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b>		First <b>William</b>		Middle <b>A.</b>		Last <b>Brewer</b>		4. DATE OF DEATH Month <b>1</b>		Day <b>25</b>		Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>2-17-10</b>		9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>49</b>		IF UNDER 24 HRS. Days <b>49</b>		Hours <b>49</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MURKIRK Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Brewer</b>		14. MOTHER'S MAIDEN NAME <b>Marie Briggs</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>441X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malignant Hypertensive-Cardio Vascular-Renal</b> (c) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		27 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Beltsville Md</b>		(County) <b>Prince Georges</b>		(State) <b>Md</b>	
21. I certify that I attended the deceased from <b>1-4</b> , 19 <b>60</b> , to <b>1-25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-25</b> , 19 <b>60</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>3503 Perry St</b>		DATE SIGNED <b>1-26-60</b>		ACTUAL SIGNATURE <b>Waldo B. Moyer</b>		M.D. <b>Waldo B. Moyer</b>		PHYSICIAN'S NAME (Type) <b>Waldo B. Moyer</b>		Mt. Rainier- Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-30-60</b>		22b. DATE THEREOF <b>1-30-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Queens Chapel</b>		22d. LOCATION (City, town, or county) <b>Murkirk Md</b>		(State) <b>Md</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>H.S. Washington &amp; Son</b>		ADDRESS <b>4925 Dean Ave</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 28 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>															

1933

January 10, 1933

Mr. J. Edgar Hoover

Federal Bureau of Investigation

Washington

Dear Sir:

Sir:

Re:

1-11-33

1

Blackburn, W.D.

James J. Pappas

Thames, George

John James, Jacksonville, Fla.

Enclosed

3 copies

Very truly yours,

J. Edgar Hoover

Special Agent in Charge

Federal Bureau of Investigation

U. S. Department of Justice

Washington, D. C.

1-11-33

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1092 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01003

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN 1b 13 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John William Brown		4. DATE OF DEATH Jan. 23, 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. II, 1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Brown		14. MOTHER'S MAIDEN NAME Jane Fobbs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Daughter Elizabeth P. Brown		Address Upper Malboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X acute congestive heart failure DUE TO (b) Cardiovascular renal disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) Upper Marlboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. Kure		24a. REC'D BY REGISTRAR JAN 26 '60	
ADDRESS 1824 N. St. U. N.W. WASH. D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

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5204



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0987

## CERTIFICATE OF DEATH

Reg. Dist. No.

01004

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>52</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR 4922 LASALLE RD.</u>				1. d. STREET ADDRESS <u>821 SHERIDAN STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>MARIE</u> Middle <u>JOSEPH</u> Last <u>BROWN</u>		4. DATE OF DEATH		Month <u>JANUARY</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 21-1984</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MR. MORRIS</u>				14. MOTHER'S MAIDEN NAME <u>Josephine m. yee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Dr. Agnes Patricia</u>		Address <u>4922 LASALLE RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x Uremia</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c.) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 days</u> <u>4 1/2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>June 1, 1957</u> to <u>Jan 10, 1960</u> , that I last saw the deceased alive on <u>Jan 10, 1960</u> , and that death occurred at <u>7:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1037 Perry St. N.E., D.C.</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>John F. Brennan</u> M.D.		PHYSICIAN'S NAME (Type) <u>John F. Brennan</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

VS A15 (4)  
1SM 9/58

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12. See: Birth Cert. et

## CERTIFICATE OF DEATH

Reg. Dist. No.

01005

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>12 Hr 30 Min</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Croome</b> d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Stephanie</b> Middle <b>Brown</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 3, 1959</b>
9. AGE (In years lost birthday) <b>1</b> yrs. <b>5</b> Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE (State or foreign country)</b> <b>Cheverly, Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
13. FATHER'S NAME <b>1</b>		14. MOTHER'S MAIDEN NAME <b>ALICE MARIE BROWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>1</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acidosis and electrolyte imbalance</b> <b>571.0</b> DUE TO (b) <b>Dehydration</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <b>Diarrhea (cause undetermined)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 9, 1960</b> to <b>JAN 9, 1960</b> that I last saw the deceased alive on <b>JAN 9, 1960</b> , and that death occurred at <b>4:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Albert J. Gaudin</b> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>1/14/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b> Administrator.		24a. REC'D BY REGISTRAR DATE <b>JAN 20 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knap</b>			

207723 4XV5

CERTIFICATE OF BIRTH

1910

IN THE STATE OF TEXAS

County of \_\_\_\_\_

State of \_\_\_\_\_

On the \_\_\_\_\_ day of \_\_\_\_\_

at \_\_\_\_\_

in the County of \_\_\_\_\_

State of \_\_\_\_\_

was born \_\_\_\_\_

to \_\_\_\_\_

and \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 1011 CERTIFICATE OF DEATH

Reg. Dist. No.

01006

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy Burgess</b>		4. DATE OF DEATH Month Day Year <b>Jan 5, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5 1960</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <b>12</b> 30
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Coy R Burgess</b>		14. MOTHER'S MAIDEN NAME <b>Shirley L Robertson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Mother</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Resorption Atelectasis</b> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atelectasis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 5, 1960</b> to <b>Jan 5, 1960</b> , that I last saw the deceased alive on <b>Jan 5, 1960</b> , and that death occurred on <b>6:30P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Benjamin S. Miller</b> M.D.		ADDRESS (Street, city or town, state) <b>3428 43th St. Mt. Rainier, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Benjamin S. Miller M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	22b. DATE THEREOF <b>1/8/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W Penn, Jr.</b>		24a. REC'D BY REGISTRAR <b>JAN 13 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>			

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[illegible]



## CERTIFICATE OF DEATH

Reg. Dist. No.

1012

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>1 Mo 22 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b> d. STREET ADDRESS <b>Bowie</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b> First Middle Last <b>Burton</b>		4. DATE OF DEATH <b>January 7 1960</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 16, 1959</b> yrs. Months Days
9. AGE (In years lost birthday) <b>1</b> yrs. <b>22</b> Months <b>22</b> Days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J C Burton</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Birdey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mother Same</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>Broncho pneumonia &amp; abscess formation</b> Conditions, if any, which gave rise to immediate cause (b) DUE TO <b>491X</b> cause (c), stating the underlying cause lost. (c) <b>491X</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 11, 1959</b> to <b>Jan 7, 1960</b> , that I last saw the deceased alive on <b>Jan 6, 1960</b> , and that death occurred at <b>2 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>3824 34th St. Mt Rainier, M.D.</b>			
ACTUAL SIGNATURE <b>Dr. Benjamin S. Miller M.D.</b>		PHYSICIAN'S NAME (Type) <b>Dr. Benjamin S. Miller M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-9-60</b>		22b. DATE THEREOF <b>1-9-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>National Harmony Am.</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhines &amp; Co. 3015-12th St. NE</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 11 60</b>	
24b. REGISTRAR'S SIGNATURE <b>1-11-60</b>			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1911

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

OCCUPATION

CAUSE OF DEATH

*John*

Nov. 11, 1911

Male

White

Heart Disease

Myocardial Infarction

Other

Physician

03

Nov. 11, 1911

Male

White

John

Myocardial Infarction

## 1000 CERTIFICATE OF DEATH

010068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				c. LENGTH OF STAY IN 1b <b>01</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Laurel General Hospital</b>				d. STREET ADDRESS <b>918 Phillip Powers Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>L.</b> Last <b>Carpenter</b>				4. DATE OF DEATH Month <b>January</b> Day <b>17</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 5, 1913</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>excavating contractor</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Claude M. Carpenter</b>				14. MOTHER'S MAIDEN NAME <b>Bess Uty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>				16. SOCIAL SECURITY NO. <b>213-05-1929</b>			
17. INFORMANT <b>Hospital records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per 18a or 18b (do not)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombotic Embolism / LSK</b> DUE TO <b>287x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Fibrillation</b> DUE TO <b>2 Month</b> (c) <b>Obesity</b> <b>20 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>20yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4/1/60</b> to <b>4/17/60</b> , that I last saw the deceased alive on <b>4/17/60</b> , and that death occurred at <b>7:45</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>J. M. Warren</b> M.D.							
PHYSICIAN'S NAME (Type) <b>J. M. WARREN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1/19/60</b>		<b>Fort Lincoln Cem.</b>		<b>Colman Manor, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edwitt Davidson, Laurel, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 22 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

## 1093 CERTIFICATE OF DEATH

Reg. Dist. No. 1009

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL-Upper Marlboro</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>"Goodland"-Clagett Landing Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Samuel</b> Last <b>Chaney</b>		4. DATE OF DEATH Month <b>January</b> Day <b>30</b> Year <b>1960.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 22, 1888</b>
9. AGE (In years lost birthday) yrs. <b>71</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tenent</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Samuel Chaney</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rebecca Foust</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>- - -</b>	
INFORMANT <b>Mrs. Ella Mae Chaney-</b>		Address <b>same as Item 2.d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>593x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Right Hemiplegia</b> DUE TO (c) <b>Hypertension - Nephritis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>One Week</b> <b>2 gm</b> <b>8 gm</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1, 1956</b> to <b>Jan 30, 1960</b> , that I last saw the deceased alive on <b>Jan. 30, 1960</b> , and that death occurred at <b>4:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Upper Marlboro, Md.</b> DATE SIGNED <b>1/30/60</b> ACTUAL SIGNATURE <b>James G. Sasscer</b> M.D. PHYSICIAN'S NAME (Type) <b>James G. Sasscer, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/2/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lothian, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Upper Marlboro, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 2 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1033  
CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01010**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN lb <b>D.O.A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>35 Bowie</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>Johnson Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Chittams</b>				<b>4. DATE OF DEATH</b> Month <b>Jan.</b> Day <b>15</b> Year <b>19 60</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>col.</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2-9-03</b>	<b>9. AGE</b> (In years last birthday) <b>56 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <b></b> Days <b></b>	<b>IF UNDER 24 HRS.</b> Hours <b></b> Min. <b></b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Mill work</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Edward Chittams</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Marie Fleets</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No.</b>		<b>16. SOCIAL SECURITY NO.</b> <b></b>		<b>17. INFORMANT</b> Address <b>Berdils Chittams; Bowie, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b></b> (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b></b>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b></b> a. m. <b></b> p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b></b>	<b>20f. (City or town)</b> (County) (State) <b></b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. (BURIAL) CREMATION, REMOVAL (Specify)</b> <b>1-18-60</b>				<b>22b. DATE THEREOF</b> <b>1-18-60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Church of Ascension Cm.</b>	
<b>22d. LOCATION (City, town, or county)</b> (State) <b>Bowie Maryland</b>				<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <i>Henry Washington 4925 Deane Ave 3</i>			
<b>24a. REC'D BY REGISTRAR</b> <b>JAN 18 '60</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Frank</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G254 1-22-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 01011

3. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>3 mo.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>74 College Park</b> d. STREET ADDRESS <b>10120 Cherry Hill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Otto</b> Last <b>Collier</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-30-20</b>
9. AGE (In years last birthday) <b>38</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam fitter</b>	11. BIRTHPLACE (State or foreign country) <b>Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Isom E. Collier</b>	
14. MOTHER'S MAIDEN NAME <b>Myrtle Woodard</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>228-12-4915</b>		INFORMANT Address <b>Helen M. Collier Same as # 2 (Wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>179.0 Carcinomatosis</b> DUE TO (b) <b>Carcinoma of Penis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>14 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 18, 1959</b> to <b>Jan. 13, 1960</b> that I last saw the deceased alive on <b>Jan. 13, 1960</b> and that death occurred at <b>2:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>College Park, Md.</b> DATE SIGNED <b>1/13/60</b>			
ACTUAL SIGNATURE <b>Wm. A. Holbrook</b>		M.D. <b>College Park, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wm. A. Holbrook, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>1/14/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Copeland Funeral Home</b>	22d. LOCATION (City, town, or county) <b>Pennington Lee Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01012

1015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND.		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret S. Cooper</u>		4. DATE OF DEATH <u>Jan - 30 - 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.G.</u>	
13. FATHER'S NAME <u>Charles Mills</u>		14. MOTHER'S MAIDEN NAME <u>Mauda Proctor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, if not unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Charles Cooper - same address</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Emboli</u> 9040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis of left iliac vein</u> DUE TO (c) <u>Fracture of left femur.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12-31</u> 1959 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>W. Hyattsville - P. Geo - Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John T. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type or print) <u>JOHN T. MALONEY, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		22d. LOCATION (City, town, or county) <u>Hyattsville, Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home</u>		24a. REC'D BY REGISTRAR <u>FEB 4 '60</u>	
ADDRESS <u>1400 Mt Rainier Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



STATEMENT OF HEALTH - BIRTH RECORD IS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to contain names, dates, and medical observations.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0988

## CERTIFICATE OF DEATH

01013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>N. Hyattsville Md. 6 yrs.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>N. Hyattsville 58</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1904-Amherst Road</b>				d. STREET ADDRESS <b>1904-Amherst Road</b>			
3. NAME OF DECEASED (Type or print) <b>EDWARD MCLELLAND COPE</b>				4. DATE OF DEATH Month <b>1</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 17, 1893</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER, RET. RAILROAD</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NAPIERVILLE, ILL.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM COPE</b>				14. MOTHER'S MAIDEN NAME <b>MARY SLESSER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>IDA COPE (Wife)</b>		Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>0</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> , 19____, to <b>1/11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/11</b> , 19 <b>60</b> , and that death occurred at <b>11:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7105 - RIGGS RD., HYATTSVILLE MD.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Hugh W. Irey</b>		M.D. <b>7105 - RIGGS RD., HYATTSVILLE MD.</b>					
PHYSICIAN'S NAME (Type) <b>HUGH W. IREY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/15/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Buncombe Perry Co. Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home Inc.</b>				ADDRESS <b>inc. Rainier</b>		24. REC'D BY REGISTRAR DATE <b>JAN 14 60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			



## 1094 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PR GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOWIE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>04BOWIE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HIGHBRIDGE ROAD</b>				d. STREET ADDRESS <b>HIGHBRIDGE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>alban F. Coulombe</b>				4. DATE OF DEATH <b>JAN 15 1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 14, 1895</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>CANADA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER, U.S. GOVT</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SERVICE ADM</b>		11. BIRTHPLACE (State or foreign country) <b>CANADA</b>	
13. FATHER'S NAME <b>ARTHUR COULOMBE</b>				14. MOTHER'S MAIDEN NAME <b>EMMA BERTRAND</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WORLDWARI</b>				16. SOCIAL SECURITY NO. <b>218-38-7276</b>			
17. INFORMANT <b>Beatrice S. Coulombe, Bowie, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>162.1</b> DUE TO <b>Bronchogenic Carcinoma Lung.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>162.1</b> DUE TO <b>Bronchogenic Carcinoma Lung.</b> (c) <b>162.1</b> DUE TO <b>Bronchogenic Carcinoma Lung.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 11, 1959</b> , to <b>Jan 15, 1960</b> that I lost saw the deceased alive on <b>Jan 13, 1960</b> , and that death occurred at <b>10:30</b> M, from the causes and on the date stated above.				21. I certify that I attended the deceased from <b>May 11, 1959</b> , to <b>Jan 15, 1960</b> that I lost saw the deceased alive on <b>Jan 13, 1960</b> , and that death occurred at <b>10:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. James Kurtz</b>				ADDRESS (Street, city or town, state) <b>RFB Bowie Md</b>			
PHYSICIAN'S NAME (Type) <b>H. James Kurtz</b>				DATE SIGNED <b>1/15/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/19/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers &amp; Son</b>				24a. REC'D BY REGISTRAR <b>JAN 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kray</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1934



## CERTIFICATE OF DEATH

01015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>REST HOME 2601 CHEVERLY AVE</b>				d. STREET ADDRESS <b>5824 JAMESTOWN RD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>F.</b> Last <b>COURTNEY</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT 29 1912</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Routeman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Lawrence Courtney</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Ambrose</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>578-05-2248</b>		17. INFORMANT <b>Mrs. Denise Courtney</b> Address <b>5824 Jamestown Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA TOSIS</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BRONCHOGENIC CARCINOMA</b> DUE TO (c) <b>6 mos</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12/19</b> 19 <b>59</b> , to <b>1/6</b> 19 <b>60</b> , that I last saw the deceased alive on <b>12/30</b> 19 <b>59</b> , and that death occurred at <b>12:35 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman Donat</b> M.D.				ADDRESS (Street, city or town, state) <b>3503 Pennycuik St</b> DATE SIGNED <b>1/4/60</b>			
PHYSICIAN'S NAME (Type) <b>NORMAN DONAT</b>				<b>BUREAU MD MT RAINIER MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-11-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Greenwood, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. Inc.</b>				24a. REC'D BY REGISTRAR <b>55 E Cleveland Ave</b> <b>Greenwood, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



*[Faint, illegible text from the reverse side of the page]*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1095

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01016

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills		c. LENGTH OF STAY IN 1b 13 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Temple Hills			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5301 Holton Lane				d. STREET ADDRESS 5301 Holton Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Woodson Cummings				4. DATE OF DEATH Month Day Year January 9, 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1908		9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10b. KIND OF BUSINESS OR INDUSTRY Laboratory		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Woodson Cummings				14. MOTHER'S MAIDEN NAME Bondurant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Rually Cummings, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) DUE TO (o), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-13-60		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat	
22d. LOCATION (City, town, or county) St. Mary's				22e. (State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE Lee F. Home - Wash. D.C.				24a. REC'D BY REGISTRAR DATE JAN 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



1096 CERTIFICATE OF DEATH

01017

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avalon,				c. LENGTH OF STAY IN 1b 1 1/2 years Aprx.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor				d. STREET ADDRESS 3133 Conn. Ave., N.W.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Mary Margaret Curtin				4. DATE OF DEATH Month Day Year January 17 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1883		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical-Bur. of Engraving -U.S. Gov.		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.		11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John J. Curtin				14. MOTHER'S MAIDEN NAME Catherine Carey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Washington D.C. Richard Curtin, Nephew, 2450 39th Pl. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pemphigus Foliaceus 704.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/18/60 to 1/17/60, that I last saw the deceased alive on 1/17/60, and that death occurred at 9 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Collins		M.D. Thomas F. Collins, M.D.		ADDRESS (Street, city or town, state) 322- H. Street, N.E.		DATE SIGNED 1/18/1960	
PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.		Washington 2, D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 20, 1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Don DeVol				ADDRESS 2224 Wis. Ave. Wash. D.C.		24a. REC'D BY REGISTRAR DATE JAN 20 '60	
						24b. REGISTRAR'S SIGNATURE Charles E. K...	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1028 CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
George Washington		Male		65	
RESIDENCE		OCCUPATION		CAUSE OF DEATH	
1234 Main St., Baltimore, Md.		Carpenter		Heart Disease	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
Jan 15, 1928		Home		Natural	
TIME OF DEATH		HOURS		MINUTES	
10:30 A.M.		10		30	
NAME OF PHYSICIAN		NAME OF BURIAL PLACE		NAME OF FUNERAL HOME	
Dr. J. H. Smith		Greenwood Cemetery		None	
NAME OF WITNESSES		NAME OF REGISTRAR		NAME OF CLERK	
John D. Brown, James E. Green		J. H. Smith		M. A. Jones	
NAME OF CLERK		NAME OF REGISTRAR		NAME OF CLERK	
M. A. Jones		J. H. Smith		M. A. Jones	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1097 CERTIFICATE OF DEATH

Reg. Dist. No. 01018

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>38 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>P.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D. C. (21)</b> d. STREET ADDRESS <b>5713-2nd Street, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEATRICE ANNE CYPRA</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>4</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 DECEMBER 1925</b>
9. AGE (In years last birthday) <b>34</b> yrs.		10. IF UNDER 1 YEAR Months <b>34</b>	11. IF UNDER 24 HRS. Days <b>34</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	11. BIRTHPLACE (State or foreign country) <b>IOWA</b>
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		13. FATHER'S NAME <b>WILLIAM MEADE (DECEASED)</b>	
14. MOTHER'S MAIDEN NAME <b>MARGARET RUTH</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>483-26-5723</b>		17. INFORMANT <b>Claude H Cypra (H)</b>	
18. ADDRESS <b>5713-2nd St, SE, Washington, DC</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>193.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>INCREASED INTRA-CRANIAL PRESSURE</b> DUE TO (c) <b>BRAIN TUMOR (GLIOBLASTOMA MULTIFORME)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 JANUARY</b> , 19 <b>60</b> to <b>4 January</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4 January</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>ANDREWS AIR FORCE BASE</b> DATE SIGNED <b>4 Jan 60</b> ACTUAL SIGNATURE <b>J. Carroll Ramseyer</b> M.D. PHYSICIAN'S NAME (Type) <b>J. CARROLL RAMSEYER, CAPT, USAF, MC</b> <b>USAF HOSPITAL ANDREWS, WASHINGTON 25, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1-5-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wahlmann Funeral Home</b>		22d. LOCATION (City, town, or county) (State) <b>Hallamsburg Iowa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wahlmann Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 8 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
SAN FRANCISCO, CALIF.

1931

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		35		Jan 15, 1931		San Francisco, Cal.	
Cause of Death		Manner of Death		Occupation		Residence		Burial Place	
Heart Disease		Natural		Teacher		123 Main St.		Cathedral of St. Mary	
Physician		Hospital		Funeral Home		Burial		Cremation	
Dr. J. Smith		St. Mary's		Doe & Sons		Yes		No	
Signature of Registrar		Signature of Physician		Signature of Funeral Home		Signature of Burial Place		Signature of Cremation	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01019

Reg. Dist. No.

1001

Items 13, 14 Film G255 1-27-60 et

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>53</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6708 Poplar Avenue</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Takoma Park</b> d. STREET ADDRESS <b>6708 Poplar Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Imogene</b> Middle <b>Davis</b> Last <b>Dempsey</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-22-12</b>
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months <b>47</b> Days <b>47</b> Hours <b>47</b> Min. <b>47</b>	IF UNDER 24 HRS. Months <b>47</b> Days <b>47</b> Hours <b>47</b> Min. <b>47</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Arkansas</b>	
11. BIRTHPLACE (State or foreign country) <b>Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>A. Davis Schutz</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Richard W. Dempsey; same address as #2</b>	
17. INFORMANT <b>Richard W. Dempsey; same address as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> <b>982X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Incised wounds of neck</b> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted incised wounds of neck</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>1-14-60</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	20f. (City or town) (County) (State) <b>Takoma Park Pr. Geo. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Jan. 14, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>Jan. 19, 60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. McGuire</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

MAXYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES M. JONES		35		Male		White		Jan. 15, 1930	
RESIDENCE		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY	
1000 North Broadway		Home		Heart Disease		Natural		None	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS	
Clerk		High School		Catholic		Married		None	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO CITY	
Jan. 15, 1895		Maryland		Jan. 15, 1910		Jan. 15, 1910		Jan. 15, 1910	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY	
Jan. 15, 1930		Home		Heart Disease		Natural		None	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS	
Clerk		High School		Catholic		Married		None	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO CITY	
Jan. 15, 1895		Maryland		Jan. 15, 1910		Jan. 15, 1910		Jan. 15, 1910	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER OF THE CITY OR COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

## 1098 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>IOWA</u> b. COUNTY <u>MONONA</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ADELPHI</u>		c. LENGTH OF STAY IN 1b <u>10 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1420 QUINWOOD ST.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UTE</u> <u>53X-3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRACE</u> <u>MARGARET</u> <u>DOROTHY</u>		4. DATE OF DEATH Month Day Year <u>JAN.</u> <u>27</u> <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 29, 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASST. Postmistress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE WINTER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET JANE CONROY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>JOSEPH DOROTHY</u>		Address <u>1420 Quinwood St, Adelphi, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of the STOMACH with</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Generalized Metastasis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>8 Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAR.</u> , 19 <u>59</u> , to <u>JUN 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JUN 26</u> , 19 <u>60</u> , and that death occurred at <u>3:36 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1806 FOX ST.</u> ACTUAL SIGNATURE <u>James L. Laubach</u> M.D. <u>Hyattsville, Md.</u> PHYSICIAN'S NAME (Type) <u>JAMES L. LAUBACH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB 1, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>	22d. LOCATION (City, town, or county) (State) <u>UTE, IOWA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. T. Atwell</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '60</u>	24b. REGISTRAR'S SIGNATURE <u>O. H. S. HANA</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
 DIVISION OF  
 HEALTH  
 JAN 11 1919

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-JANUARY 18

NAME OF DECEASED JOHN J. HARRIS		SEX MALE		AGE 45	
PLACE OF BIRTH BALTIMORE, MARYLAND		OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH JANUARY 10, 1918		TIME OF DEATH 10:30 A.M.		PLACE OF DEATH HOME	
NAME OF PHYSICIAN DR. J. H. HARRIS		NAME OF FUNERAL HOME HARRIS & SONS		NAME OF BURIAL PLACE GREENWOOD CEMETERY	
NAME OF NEXT OF KIN MRS. J. H. HARRIS		NAME OF WITNESS J. H. HARRIS		NAME OF REGISTRAR J. H. HARRIS	
NAME OF CITY OR TOWN BALTIMORE		NAME OF COUNTY BALTIMORE		NAME OF STATE MARYLAND	
NAME OF DISTRICT BALTIMORE		NAME OF WARD BALTIMORE		NAME OF BLOCK BALTIMORE	
NAME OF STREET BALTIMORE		NAME OF ALLEY BALTIMORE		NAME OF LOT BALTIMORE	
NAME OF HOUSE BALTIMORE		NAME OF APARTMENT BALTIMORE		NAME OF ROOM BALTIMORE	
NAME OF BUILDING BALTIMORE		NAME OF FLOOR BALTIMORE		NAME OF ROOM BALTIMORE	
NAME OF CITY OR TOWN BALTIMORE		NAME OF COUNTY BALTIMORE		NAME OF STATE MARYLAND	
NAME OF DISTRICT BALTIMORE		NAME OF WARD BALTIMORE		NAME OF BLOCK BALTIMORE	
NAME OF STREET BALTIMORE		NAME OF ALLEY BALTIMORE		NAME OF LOT BALTIMORE	
NAME OF HOUSE BALTIMORE		NAME OF APARTMENT BALTIMORE		NAME OF ROOM BALTIMORE	
NAME OF BUILDING BALTIMORE		NAME OF FLOOR BALTIMORE		NAME OF ROOM BALTIMORE	

## CERTIFICATE OF DEATH

Reg. Dist. No.

01021

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville MD</i>		c. LENGTH OF STAY IN 1b <i>2 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CARROLL MANOR</i>		e. STREET ADDRESS <i>2706 Plover Mill Rd</i>	
3. NAME OF DECEASED (Type or print) First <i>CATHERINE</i> Middle <i>A.</i> Last <i>Dwyer</i>		4. DATE OF DEATH Month <i>JAN.</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>FEB. 15, 1877</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>JOHN O'CONNOR</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>ROBERT DWYER</i>		Address <i>ABOVE (Son)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>3 yrs</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug</i> , 19 <i>57</i> , to <i>Jan 11</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Jan 9</i> , 19 <i>60</i> , and that death occurred at <i>3:45</i> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William T. Saccardi</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>1150 Conn Ave N.W. 1/11/60</i>	
PHYSICIAN'S NAME (Type) <i>WILLIAM T. SACCARDI</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>JAN. 13, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>ST JOHN'S</i>	22d. LOCATION (City, town, or county) (State) <i>Forest Glen MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter A. ...</i>		24a. REC'D BY REGISTRAR <i>...</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



...the ... of ...





1099 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Hillside</u>			
c. LENGTH OF STAY IN 1b <u>45 yrs</u>				d. STREET ADDRESS <u>1100-59<sup>th</sup> ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1100-59<sup>th</sup> ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Ether</u> Last <u>X</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 1-1867</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Wash DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Moog</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Emma M. Berry Wash DC</u> Address <u>1309-Annapolia Rd SE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 23, 1960</u> , to <u>Jan 25, 1960</u> , that I last saw the deceased alive on <u>Jan 23, 1960</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2200 Marlboro Pike SE 1-25%</u> DATE SIGNED <u>  </u>							
ACTUAL SIGNATURE <u>James T. Boyd</u> M.D. <u>Wash DC</u>							
PHYSICIAN'S NAME (Type) <u>James T. Boyd</u> <u>Wash DC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-28-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Mattingly</u> ADDRESS <u>131-11<sup>th</sup> St NE Wash DC</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1900 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

<p>NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>AGE</p> <p><i>45</i></p>	
<p>SEX</p> <p><i>Male</i></p>		<p>DATE OF BIRTH</p> <p><i>Jan 15 1855</i></p>	
<p>PLACE OF BIRTH</p> <p><i>England</i></p>		<p>DATE OF DEATH</p> <p><i>Dec 10 1900</i></p>	
<p>CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>PLACE OF DEATH</p> <p><i>Home</i></p>	
<p>DATE OF INTERMENT</p> <p><i>Dec 12 1900</i></p>		<p>PLACE OF INTERMENT</p> <p><i>Cemetery</i></p>	
<p>SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p>		<p>SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>	
<p>DATE OF SIGNATURE</p> <p><i>Dec 10 1900</i></p>		<p>DATE OF SIGNATURE</p> <p><i>Dec 10 1900</i></p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 19

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1071 CERTIFICATE OF DEATH

Reg. Dist. No.

01023

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>69 Berwyn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hospital</u>		d. STREET ADDRESS <u>9517 Baltimore Blvd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MINNA</u> Middle <u>LOUISE</u> Last <u>EDMUNDS</u>		4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-86</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Greer</u>		14. MOTHER'S MAIDEN NAME <u>Anna Hutchins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218 20 1316</u>	
17. INFORMANT <u>Hospital Record</u>		Address <u>Riverdale, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolism</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hr</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. <u>  </u> p. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 24</u> , 19 <u>60</u> , to <u>Jan 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 25</u> , 19 <u>60</u> , and that death occurred at <u>9:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Roy B. Parsons</u> M.D.		ADDRESS (Street, city or town, state) <u>4408 24th St. Riverdale, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Roy B. Parsons</u>		DATE SIGNED <u>1-25-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland.</u>	
24a. REC'D BY REGISTRAR <u>JAN 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG254 1-21-60 et

## CERTIFICATE OF DEATH

01024

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>(Joseph) Guiseppe Enrico</b>		4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-8-1896</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carmen Enrico</b>		14. MOTHER'S MAIDEN NAME <b>Rose Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Carmen Enrico</b>		18. ADDRESS <b>6000 Rosedale Drive West Hyattsville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 1</b> , 19 <b>60</b> , to <b>Jan 14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 14</b> , 19 <b>60</b> , and that death occurred at <b>7:00</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dayton Watkins</b>		DATE SIGNED <b>Jan 14 1960</b>	
PHYSICIAN'S NAME (Type) <b>DAYTON WATKINS</b>		ADDRESS (Street, city or town, state) <b>5304 Annapolis Rd. Bladensburg Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-19-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wash. DC</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Mittingly</b>		24a. REC'D BY REGISTRAR <b>Jan 18 '60</b>	
ADDRESS <b>131-11 St. Wash. DC</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. King</b>	



DOI: 10.1002/for

Journal of Management Education 36(1)



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01025

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 Bladensburg</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4310 Baltimore Avenue</b>				d. STREET ADDRESS <b>4310 Baltimore Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Dallas</b> Middle <b>Patrick</b> Last <b>Fisher</b>				4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-21- 1891</b>	9. AGE (In years last birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Theodore Fisher</b>				14. MOTHER'S MAIDEN NAME <b>Margaret D. Felker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.1 136-09-4228</b>		17. INFORMANT <b>Nannie M. Whorton; same address as # 2.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>January 31, 1960</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/3/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Ceme.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Garach's Sons</b> ADDRESS <b>Hyattsville, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 4 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraw</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
 DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
PREVIOUS ILLNESS [REDACTED]		PRESENT ILLNESS [REDACTED]		TREATMENT [REDACTED]	
SIGNATURE OF MEDICAL EXAMINER [REDACTED]		SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
CERTIFICATE NO. [REDACTED]		COUNTY [REDACTED]		CITY [REDACTED]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1018

CERTIFICATE OF DEATH

Reg. Dist. No.

01026

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b>		4. DATE OF DEATH <b>Jan. 6, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 4, 1960</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Robert L.</b>		14. MOTHER'S MAIDEN NAME <b>Annabell Elaine Boswell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mother</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.4</b> DUE TO <b>Subacute cardiac fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Assoc. w mult. org. anomalies</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 4</b> , 1960, to <b>Jan 6</b> , 1960, that I last saw the deceased alive on <b>Jan 6</b> , 1960, and that death occurred at <b>3:55 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George Haggage</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	22b. DATE THEREOF <b>1/11/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b>		24a. REC'D BY REGISTRAR <b>JAN 13 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Harry W. Penn, Jr.</b>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077182XU3

1019 CERTIFICATE OF DEATH

NAME OF DECEASED  
AGE  
SEX  
DATE OF BIRTH

DATE OF DEATH  
PLACE OF DEATH  
CITY

CAUSE OF DEATH  
MANNER OF DEATH

SIGNATURE OF PHYSICIAN  
DATE

SIGNATURE OF WITNESSES  
DATE

SIGNATURE OF DECEASED  
DATE

SIGNATURE OF DECEASED  
DATE

SIGNATURE OF DECEASED  
DATE

SIGNATURE OF DECEASED  
DATE

SIGNATURE OF DECEASED  
DATE

0990

## CERTIFICATE OF DEATH

01027

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Rhode Island</b> b. COUNTY <b>16</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. LENGTH OF STAY IN 1b <b>2 1/2 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8910 Riggs Road</b>				e. STREET ADDRESS <b>61 Park(Street) Avenue</b>			
				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>M. Marie de la Victoire</b> First <b>C.</b> Middle <b>Foisy</b> Last				4. DATE OF DEATH Month <b>1</b> Day <b>30</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 23, 1872</b>	
				9. AGE (In years) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Religious</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Catholic Nun</b>		11. BIRTHPLACE (State or foreign country) <b>Central Falls, R.I.</b>	
13. FATHER'S NAME <b>Olivier Foisy</b>				14. MOTHER'S MAIDEN NAME <b>Marcelline Dauray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Regina Convent Records 8910 Riggs Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis, generalized</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>Sept</b> , 19 <b>52</b> , to <b>Jan 30</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 27</b> , 19 <b>60</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William F. Simpson, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>6216 N.H. Ave. N.E.</b>		DATE SIGNED <b>1/30/60</b>	
PHYSICIAN'S NAME (Type) <b>William F. Simpson Jr.</b>				<b>Washington, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-2-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Regina Convent Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>				ADDRESS <b>Wash. D. C.</b>		24a. REC'D BY REGISTRAR <b>Francis J. Collins</b>	
<b>FRANCIS J. COLLINS 3821 14th. ST. N.W.</b>				DATE <b>FEB 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0991

CERTIFICATE OF DEATH

Reg. Dist. No.

01028

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>New York</b> b. COUNTY <b>New York</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. LENGTH OF STAY IN 1b <b>35 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>8910 Riggs Road</b>				e. STREET ADDRESS <b>225 West 14 th St.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>(Sister St. Lea) Marie Almida Fournier</b>				4. DATE OF DEATH Month Day Year <b>January 13 1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 7, 1892</b>		9. AGE (In years lost birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RELIGIOUS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CATHOLIC NUN</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>	
13. FATHER'S NAME <b>Cleophas Fournier</b>				14. MOTHER'S MAIDEN NAME <b>Adeline Goulet</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Regina Convent Records 8910 Riggs Road</b> Address <b>Hyatts. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>11 months</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>DEC. 10, 1959</b> , to <b>JAN. 13, 1960</b> , that I last saw the deceased alive on <b>JAN. 8, 1960</b> , and that death occurred at <b>7:50 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1806 Fox St.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>James R. Laubach</b> M.D. PHYSICIAN'S NAME (Type) <b>JAMES L. LAUBACH</b> <b>Hyattsville, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 15, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Regina Convent Cemetery</b>		22d. LOCATION (City, town, or county)		(State) <b>Hyattsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b> ADDRESS <b>Wash. D. C. 3821 14th. St. N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

DECEASED NAME (Last, first, middle initial) (Print or type)		SEX (Male or Female) (Print or type)		AGE (In years, months, and days) (Print or type)	
DATE OF BIRTH (Month, day, year) (Print or type)		PLACE OF BIRTH (City, State, and Country) (Print or type)		RACE (Print or type)	
MARRIAGE (Date and place) (Print or type)		OCCUPATION (Print or type)		CAUSE OF DEATH (Print or type)	
MEDICAL HISTORY (Print or type)		PRESENT ILLNESS (Print or type)		DATE OF DEATH (Month, day, year) (Print or type)	
PLACE OF DEATH (City, State, and Country) (Print or type)		TIME OF DEATH (Print or type)		SIGNATURE OF DECEASED (Print or type)	
SIGNATURE OF WITNESS (Print or type)		SIGNATURE OF PHYSICIAN (Print or type)		SIGNATURE OF CORONER (Print or type)	
SIGNATURE OF JUDGE (Print or type)		SIGNATURE OF CLERK (Print or type)		SIGNATURE OF REGISTRAR (Print or type)	

RECORDED IN

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be sent to the local health officer of the city or county in which the death occurred.

1067

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo. Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Savage</b> <b>13X-2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>21 Main Street</b>				d. STREET ADDRESS <b>Guilford</b>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Leon</b> Last <b>Frazier</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>20</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 1, 1913</b>		9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machinist</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Franklin Frazier</b>				14. MOTHER'S MAIDEN NAME <b>Katie Florence Stoneburner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-26-0758</b>		17. INFORMANT <b>Joyce Harman; 6506 Harman Avenue Elkridge, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hemorrhage</b> <b>783.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Bleeding from bronchiectatic cavity</b> (a), stating the underlying cause last. DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Jan 23 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Savage Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Savage, Howard - Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. [Signature]</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1062

Items 8, 9 Film G258 3-7-60 et

## CERTIFICATE OF DEATH

01030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FARM MOUNT HTS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FARM MOUNT HTS</u>			
c. LENGTH OF STAY IN 1b <u>39 yrs</u>				d. STREET ADDRESS <u>6211 - H. St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6211 - H. St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Flitah Galloway</u>				4. DATE OF DEATH <u>JAN - 27 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>(N)</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB - 25 1869</u>	
9. AGE (In years last birthday) <u>90 1/2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Galloway</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>JAN - 6</u> , 19 <u>60</u> to <u>JAN 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JAN 27</u> , 19 <u>60</u> , and that death occurred at <u>10:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.C. Beldon</u>				ADDRESS (Street, city or town, state) <u>4423 - HUNT PI - NE</u>			
NAME (Type) <u>H.C. Beldon</u>				DATE SIGNED <u>Wash 19 - DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>		22b. DATE THEREOF <u>2-2-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Brimm Rd SE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Washington</u>				24a. REC'D BY REGISTRAR <u>FEB 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/58





1019

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>17 Hr</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b> d. STREET ADDRESS <b>6580 Rock Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Helen M Gaus</b>				4. DATE OF DEATH Month Day Year <b>Jan. 7 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 12, 1902</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>XXXXXXXXXX</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>XXXXXXXXXX George C. Thompson</b>				14. MOTHER'S MAIDEN NAME <b>XXXXXXXXXX Mary Agnes Wible</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>XXXXXXXXXX</b>			
17. INFORMANT <b>Robert Scully</b>				Address <b>1824 Old Md Georgetown Rd Bethesda</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage from bleeding esophageal varices</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cirrhosis of the liver.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>3824 34th St.</b>				20g. (County) <b>Mt Rainier, Md.</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>Jan. 6</b> , 19 <b>60</b> , to <b>Jan 7</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 7</b> , 19 <b>60</b> , and that death occurred at <b>8A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3824 34th St. Mt Rainier, Md.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>Benjamin S. Miller</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Benjamin S. Miller M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-9-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Johns Wash DC</b>		22d. LOCATION (City, town, or county) (State) <b>Hollywood Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. G. Mattingly</b> <b>B.R. 660</b>				24. REC'D BY REGISTRAR <b>131-11th St. S.E.</b> <b>Jan 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1012  
CERTIFICATE OF DEATH

IN THE

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## 1020 CERTIFICATE OF DEATH

Reg. Dist. No.

01032

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>7 da.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Naomi Giddens</b>		4. DATE OF DEATH <b>Jan. 13 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-13-96</b>
9. AGE (In years lost birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Groome</b>		14. MOTHER'S MAIDEN NAME <b>Magneta Musgrove</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>George W. Giddens</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Broncho pneumonia RT.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerotic Rh de.</b> DUE TO <b>1 month</b> (c) <b>Congestive heart failure</b> DUE TO <b>4 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 5</b> , 19 <b>60</b> , to <b>JAN 13</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>JAN 13</b> , 19 <b>60</b> , and that death occurred at <b>9 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leon R. Levitsky</b>		ADDRESS (Street, city or town, state) <b>3408 Rhode Island Ave Mt Rainier Md</b>	
PHYSICIAN'S NAME (Type) <b>Leon R. Levitsky</b>		DATE SIGNED <b>1-14-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-18-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Fort Myer, Va</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. G. Mattingly</b>		24a. REC'D BY REGISTRAR <b>1 5 '60</b>	
ADDRESS <b>131-11th St. S.E. Atlanta Ga 30600</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> c. LENGTH OF STAY IN lb <u>47 Mt. Rainier</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 Mt. Rainier</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4016-33rd Street</u>				d. STREET ADDRESS <u>4016-33rd St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Andrew R. Gill</u>				4. DATE OF DEATH <u>Jan. 31</u>		Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/75</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cressman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>G.P.O.</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Norman Gill</u>				14. MOTHER'S MAIDEN NAME <u>Araminta Parsons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT <u>E. Estelle Gill, wife</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cerebral Thrombosis</u> (c) <u>Arteriosclerotic Cardio Vascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>15 months</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Colostomy from operation for Carcinoma of Rectum 1951</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-8</u> , 19 <u>58</u> , to <u>1-31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-31</u> , 19 <u>60</u> , and that death occurred at <u>Mt. Rainier</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Waldo B. Moyers</u> M.D. <u>3503 Perry St</u>				PHYSICIAN'S NAME (Type) <u>Waldo B. Moyers</u> <u>Mt. Rainier, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home</u>		ADDRESS <u>Mt. Rainier</u>		24a. REC'D BY REGISTRAR <u>Feb 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO HOSPITAL C**

**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with



1034

## CERTIFICATE OF DEATH

9/26/63 enc.

01072

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Hillside</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>			d. STREET ADDRESS <b>14900 I Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Baby Boy Theodore Robert Grant Miller</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>8</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-23-1959</b>	9. AGE (In years lost birthday) yrs. <b>17</b>	IF UNDER 1 YEAR Months <b>17</b> Days <b>17</b> Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harvey Charles James Grant</b>			14. MOTHER'S MAIDEN NAME <b>Virginia Ardeeser</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or date of service)		INFORMANT <b>Mother</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>763.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atelectasis</b> DUE TO (c) <b>Prenatality</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>Dec. 23</b> , 19 <b>59</b> , to <b>Jan. 8</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan. 8</b> , 19 <b>60</b> , and that death occurred at <b>145A</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>John W. Perkins</b>		ADDRESS (Street, city or town, state) <b>5301 Hamilton St., Hyattsville, Md.</b> DATE SIGNED <b>1/8/60</b>			
PHYSICIAN'S NAME (Type) <b>John W. Perkins</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	22b. DATE THEREOF <b>1/11/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b> kAdministrator.		24a. REC'D BY REGISTRAR DATE <b>JAN 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2277277XV27

CERTIFICATE OF DEATH

*[Faint, mostly illegible text and markings on a certificate form, including fields for name, date, and cause of death.]*

1100

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) o. STATE <b>D. C.</b> b. COUNTY <b>-</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47 x - 3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>1810 Kalorama Rd., N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Norma</b> Middle <b>Crawford</b> Last <b>Gross</b>		4. DATE OF DEATH <b>Apr. #2</b> Day <b>1</b> Year <b>17 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/24/13</b>
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John E. Crawford</b>		14. MOTHER'S MAIDEN NAME <b>Emma Blackwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-22-3977</b>	
17. INFORMANT <b>Decedent</b>		Address <b>-</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the esophagus</b> <b>150 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002 x Pulmonary tuberculosis</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/4/</b> , 19 <b>59</b> , to <b>1/17/</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/17/</b> , 19 <b>60</b> , and that death occurred at <b>11:50AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Glenn Dale Hospital</b> <b>1/17/60</b> ACTUAL SIGNATURE <b>Moe Weiss</b> M.D. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b> <b>Glenn Dale, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-20-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Moley, Moley, J. H.</b>		24a. REC'D BY REGISTRAR <b>20 60</b>	
ADDRESS <b>2718 15th St. N.E.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

Name of Deceased \_\_\_\_\_  
Age \_\_\_\_\_ Sex \_\_\_\_\_  
Date of Death \_\_\_\_\_  
Place of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_  
Signature of Registrar \_\_\_\_\_  
Signature of Informant \_\_\_\_\_

Signature of Coroner \_\_\_\_\_  
Signature of Minister of the Gospel \_\_\_\_\_

Signature of Burial Officer \_\_\_\_\_  
Signature of Undertaker \_\_\_\_\_

Signature of \_\_\_\_\_  
Signature of \_\_\_\_\_

Signature of \_\_\_\_\_  
Signature of \_\_\_\_\_

Signature of \_\_\_\_\_  
Signature of \_\_\_\_\_

Signature of \_\_\_\_\_  
Signature of \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01035

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>		c. LENGTH OF STAY IN 1b <b>5 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>28 Seat Pleasant</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7505 F Street</b>				d. STREET ADDRESS <b>7505 F Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Maude V. Haines</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>15</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1878</b>		9. AGE (in years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Newport, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Cless</b>				14. MOTHER'S MAIDEN NAME <b>Sarah A. Cless</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Theodore Weibley</b> Address <b>Same as (D)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio Vascular Renal Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James I. Boyd</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>January 15, 1960.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/20/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>NEWPORT</b>		22d. LOCATION (City, town, or county) (State) <b>NEWPORT, PENNA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO</b>				ADDRESS <b>Riverdale, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 21 '60</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kram</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED JAMES E. BROWN</p>		<p>AGE 25 YRS.</p>		<p>SEX MALE</p>	
<p>RESIDENCE 1234 E. STREET</p>		<p>CITY BALTIMORE</p>		<p>COUNTY BALTIMORE</p>	
<p>DATE OF DEATH JAN. 15, 1920</p>		<p>TIME OF DEATH 10:30 A.M.</p>		<p>PLACE OF DEATH HOME</p>	
<p>CAUSE OF DEATH DIPHTHERIA</p>		<p>MANNER OF DEATH NATURAL</p>		<p>EDUCATION HIGH SCHOOL</p>	
<p>PREVIOUS ILLNESS DIPHTHERIA</p>		<p>PREVIOUS SURGERY NONE</p>		<p>PREVIOUS TRAUMA NONE</p>	
<p>TESTS NONE</p>		<p>TREATMENT NONE</p>		<p>POST-MORTEM NONE</p>	
<p>SIGNATURE OF EXAMINER J. E. BROWN</p>		<p>DATE JAN. 15, 1920</p>		<p>PLACE BALTIMORE</p>	



## 1021 CERTIFICATE OF DEATH

Reg. Dist. No.

01036

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>Star Rt. 23 Chesapeake Beach</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>William Douglas</b> Middle <b>Richard</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>18</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-14-59</b>	
9. AGE (In years lost birthday) yrs. <b>2</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>0</b> Hours <b>4</b> Min. <b>2</b>		IF UNDER 24 HRS. Hours <b>4</b> Min. <b>2</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Douglas Jaye Hall</b>				14. MOTHER'S MAIDEN NAME <b>Eva Blake</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Eva Blake Hall-</b>			
17. ADDRESS (Same as above.) <b>same as above.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Bilateral bronchopneumonia</b> DUE TO (c) <b>2 days</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan. 17 1960</b> to <b>Jan. 18 1960</b> I last saw the deceased alive on <b>Jan. 18 1960</b> and that death occurred at <b>9:20 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lewis Parker</b>				ADDRESS (Street, city or town, state) <b>5241 St. Barnabas Rd 11060</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Parker</b>				DATE SIGNED <b>Oxon Hill, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/21/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington National Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home-</b>				ADDRESS <b>Upper Marlboro, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 22 60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2064171XV3

1001 CERTIFICATE OF DEATH

1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Age: [illegible]

4. Sex: [illegible]

5. Race: [illegible]

6. Cause of death: [illegible]

7. Place of death: [illegible]

8. Signature of physician: [illegible]

9. Signature of registrar: [illegible]

10. Date of registration: [illegible]

11. Signature of informant: [illegible]

12. Signature of registrar: [illegible]

13. Date of registration: [illegible]

14. Signature of registrar: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G255 1/27/60 iwk

## 1022 CERTIFICATE OF DEATH

Reg. Dist. No.

01057

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beaver Heights</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Willard</b> Middle <b>Hamilton</b> Last <b>Hamilton</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jul. 14, 1922</b>
9. AGE (In years last birthday) <b>38 1/2</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>17</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Orderly Glendell Hospital D.C.Gov.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Hamilton</b>		14. MOTHER'S MAIDEN NAME <b>Gussie Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe Hypertension</b> DUE TO (c) <b>Renal Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>3 yrs</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 1956 to <b>Jan</b> , 1960 that I last saw the deceased alive on <b>Jan 15</b> , 1960, and that death occurred at <b>2:30AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Henry A. Wise Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>9005 Volta St Lanham, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Henry A. Wise Jr.</b>		DATE SIGNED <b>Jan 15 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1.20.60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert G. McQuinn</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 20 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01038

1022

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2mo.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>46 Brentwood</b> d. STREET ADDRESS <b>14506- 39th. St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>J.</b> Last <b>Hanly</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>12</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-7-89</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cremaker (Ret)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Penn R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>Altoona Pa</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>							
13. FATHER'S NAME <b>John Peter Hanly</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Mc Intosh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>716-05-5159</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>465X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Multiple Pulmonary Emboli</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov. 13, 1959</b> to <b>Jan. 12, 1960</b> , that I last saw the deceased alive on <b>Jan. 12, 1960</b> , and that death occurred at <b>12:05 P.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3503 Pet-ty St 1-12-60</b> DATE SIGNED ACTUAL SIGNATURE <b>Waldo B. Moyers</b> M.D. <b>3503 Pet-ty St 1-12-60</b> PHYSICIAN'S NAME (Type) <b>Waldo B. Moyers</b> <b>MT. Rainier Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>SHIP RR 1-13-1960</b>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery Altoona Pa</b>	
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. 5801 Cleveland ave</b>				ADDRESS <b>Baltimore Md.</b>		24a. REG'D BY REGISTRAR <b>JAN 15 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred E. Hanks</b>							

STATE OF TEXAS  
COUNTY OF DALLAS

IN SENATE

January 1, 1901

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

FOR THE

YEAR 1900

AND

FOR THE

YEAR 1901

AND

FOR THE

YEAR 1902

AND

FOR THE

YEAR 1903



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1101 CERTIFICATE OF DEATH

Reg. Dist. No.

01039

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRISTOL (RURAL)</b> 02X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>				d. STREET ADDRESS <b>NONE</b>			
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>MAE</b> Last <b>HARDESTY</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>7</b> Year <b>19 60</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 DECEMBER 1905</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>HOWARD TUCKER</b>				14. MOTHER'S MAIDEN NAME <b>MARY V TUCKER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT Shirley</b>		Address <b>MRS. <del>HEAT</del> TICHY(D) BRISTOL, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>VENTRICULAR FIBULATION</b> (c) <b>ARTERIOSCLEROTIC CORONARY ARTERY DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>IMMEDIATE</b> <b>1-2 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7 JANUARY</b> , 19 <b>60</b> , to <b>7 JANUARY</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>7 JANUARY</b> , 19 <b>60</b> , and that death occurred at <b>0920A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>ANDREWS AIR FORCE BASE</b> DATE SIGNED <b>7 JAN 60</b> ACTUAL SIGNATURE <b>Thomas D. B. Fennell</b> M.D. PHYSICIAN'S NAME (Type) <b>THOMAS D. B. FENNELL, CAPT, USAF, MC</b> <b>USAF HOSPITAL ANDREWS, WASHINGTON 25, D.C.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Smithville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home</b>				ADDRESS <b>Upper Marlboro, Md.</b>		24a. REGISTRAR'S SIGNATURE <b>24b. REGISTRAR'S SIGNATURE</b>	

JAN 18 60

Arthur S. Hume

1.  $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1102

01040

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>T.B.</u>		c. LENGTH OF STAY IN 1b <u>Heedonamel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheltenham</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dobsons Hospital</u>			d. STREET ADDRESS <u>Box 322B UPPER MARLBORO</u>		
3. NAME OF DECEASED (Type or print) <u>John Wesley Harris</u>			4. DATE OF DEATH <u>Jan 17 1960</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>3-22-1901</u>		9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>	
14. FATHER'S NAME <u>UNKNOWN</u>			15. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			17. SOCIAL SECURITY NO. <u>19368531</u>		
18. INFORMANT <u>GERALDINE BROWN</u>			19. ADDRESS <u>RFD #7 Box 346B UPPER MARLBORO MD</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO (b) <u>Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Cardiovascular renal disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>		20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-17-60</u>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>First Methodist Church</u>	
22d. LOCATION (City, town, or county) <u>Waldorf</u>		(State) <u>MD.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Ballins</u>	
ADDRESS <u>Hunt Pl., N.E., D.C.</u>		24a. REC'D BY REGISTRAR <u>Jan 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1102

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, and cause of death.

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ RACE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

EDUCATION: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

MODE OF DEATH: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

TIME OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

EXAMINER'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Vertical text on the right margin, likely a filing or processing note.

01041

## 1103 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Du Pont Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookes Rest Home</u>		d. STREET ADDRESS <u>4429 Spaulding Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Estella</u> Last <u>Harris</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Tom Hogan</u>		14. MOTHER'S MAIDEN NAME <u>Lettie (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>William Harris - 4429 Spaulding Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> , 19____, to <u>1960</u> , 19____, that I last saw the deceased alive on <u>1-18-</u> 19 <u>60</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1001 Eastern Ave, N.E.</u> DATE SIGNED ACTUAL SIGNATURE <u>John W. Robinson</u> M.D. PHYSICIAN'S NAME (Type) <u>John W. Robinson, M.D.</u> <u>Washington 27-D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-23-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Galline</u>		ADDRESS <u>4339 Hunt Pk</u> REC'D BY REGISTRAR <u>JAN 22 '60</u> DATE <u>Wash. D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
JAMES EARL RAY		M		39		12-1-28		MOBILE, ALABAMA		COUNSELLOR	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
4-4-68		11:00 AM		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		[Signature]	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN		17. SIGNATURE OF CLERK		18. SIGNATURE OF CHIEF OF POLICE	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

18

RECEIVED  
MAY 10 1968  
BALTIMORE, MARYLAND  
STATE DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND



OK BY DR JOHN MALONEY, CONOVER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0992

CERTIFICATE OF DEATH

01042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. LENGTH OF STAY IN 1b <u>35 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5010 37TH PL</u>				d. STREET ADDRESS <u>5010 37TH PL</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARIE</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 7 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HOLLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unk.</u>				14. MOTHER'S MAIDEN NAME <u>MARIA CATHERINA OUDT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>MR BASTIAN HELLO</u> Address <u>5010 37TH PL HYATTS. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> <u>5 yrs</u> DUE TO (c) <u>Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>MARCH</u> , 19 <u>51</u> , to <u>JAN 20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JAN 7</u> , 19 <u>60</u> , and that death occurred at <u>5<sup>00</sup></u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3503 PENNY ST</u> DATE SIGNED <u>1/20/60</u> ACTUAL SIGNATURE <u>Norman Dorat Comen</u> M.D. <u>MT Rainier MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				22b. DATE THEREOF <u>23 Jan 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Colmar Manor</u> (State) <u>Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

01043

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>NONE</b> Maryland b. COUNTY <b>NONE</b> Pr.Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		c. LENGTH OF STAY IN 1b <b>27 MINS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS, ANDREWS AFB</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NEWBORN HENDRY</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>9</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 JANUARY 1960</b>
9. AGE (In years last birthday) <b>0</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. <b>27</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEE F. HENDRY</b>		14. MOTHER'S MAIDEN NAME <b>ANN CHEKEVDIA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EXTREME PREMATUREITY</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>27 MINS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9 JANUARY</b> , 19 <b>60</b> , to <b>9 JANUARY</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9 JANUARY</b> , 19 <b>60</b> , and that death occurred at <b>1052 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Vincent P Ringrose Jr.</i>		M.D. <b>USAF HOSPITAL ANDREWS, ANDREWS AFB WASH 25 DC</b>	
PHYSICIAN'S NAME (Type) <b>VINCENT P RINGROSE JR, CAPT, USAF, MC USAF HOSPITAL ANDREWS, ANDREWS AFB WASH DC</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Marque, Wash. DC</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>hoss</i>		24a. REC'D BY REGISTRAR DATE <b>JAN 15 '60</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur J. Hous</i>

2050265 XV0

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1105

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights		c. LENGTH OF STAY IN 1b 8 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 Cedar Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1116 64th Avenue				d. STREET ADDRESS 1 1116 64th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Hopkins				4. DATE OF DEATH Month January Day 21 Year 19 60			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 60?		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Hopkins				14. MOTHER'S MAIDEN NAME Martha Quinn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Sadie Anderson; same address as # 2. Dr. Phillips; Crownsville State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease. (c) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED January 21, 1960			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 46/1/60		22c. NAME OF CEMETERY OR CREMATORY University of Maryland		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese				ADDRESS 1116 64th Avenue		24a. REC'D BY REGISTRAR DATE Jan 21 1960	
				24b. REGISTRAR'S SIGNATURE Charles E. Kline			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
RACE [REDACTED]		OCCUPATION [REDACTED]		PLACE OF BIRTH [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
PRESENT ILLNESS [REDACTED]		PREVIOUS ILLNESSES [REDACTED]		SURGICAL HISTORY [REDACTED]	
PHYSICIAN'S SIGNATURE [REDACTED]		MEDICAL EXAMINER'S SIGNATURE [REDACTED]		JURY OF INQUEST SIGNATURE [REDACTED]	
DATE OF SIGNATURE [REDACTED]		DATE OF SIGNATURE [REDACTED]		DATE OF SIGNATURE [REDACTED]	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01045

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>			c. LENGTH OF STAY IN 1b <b>1 Year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>320 Talbot Ave.</b>				d. STREET ADDRESS <b>Talbot Ave. # 320</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>THOMAS</b> First <b>NEISH</b> Middle <b>HOSKINSON</b> Last				4. DATE OF DEATH Month <b>Jan</b> Day <b>27</b> Year <b>1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>1 Dec. 1910</b>			
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Jack Hoskinson</b>				14. MOTHER'S MAIDEN NAME <b>Anna Neish</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1942</b>		17. INFORMANT <b>444 Carolina Ave. Dale K. Allison Chester, West Va. (Friend)</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<b>January 28, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arner Funeral Home</b>			22d. LOCATION (City, town, or county) (State) <b>East Liverpoole Ohio</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01046

1072

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) City Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 62 Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital		d. STREET ADDRESS 5206 42nd Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALICE Middle VIRGINIA Last HULTBERG		4. DATE OF DEATH Month January Day 1 Year 19 60	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1871
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Stephen Hunter Williams		14. MOTHER'S MAIDEN NAME Sarah Poindexter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Hospital chart
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerotic heart disease DUE TO (c) 24 yrs 2 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 19 58 to Jan. 1, 19 59, that I last saw the deceased alive on May 31, 19 59, and that death occurred at 9:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lawrence W. Malin		ADDRESS (Street, city or town, state) Riverdale, Md. 21152	
DATE SIGNED MAY 12 1959			
PHYSICIAN'S NAME (Type) Lawrence W. Malin, M. D., 4404 Queensbury Rd., Riverdale, Maryland			
22a. DATE OF CREMATION Jan. 6, 1960		22b. NAME OF CREMATOR Fort Lincoln Crematory	
22c. LOCATION (City, town, or county) Bladensburg, Maryland.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,		ADDRESS Riverdale, Maryland.	
24a. REC'D BY REGISTRAR DATE JAN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

Reg. Div. No.

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF DEATH April 4, 1968	
5. PLACE OF DEATH Memphis, Tennessee		6. COUNTY Shelby	
7. MANNER OF DEATH Homicide		8. CAUSE OF DEATH Shot	
9. PLACE OF BIRTH Sikeston, Missouri		10. OCCUPATION None	
11. MARITAL STATUS Single		12. EDUCATION High School	
13. RELIGION Methodist		14. SIGNATURE OF DECEASED James Earl Ray	
15. SIGNATURE OF NEXT OF KIN Johnnie Lee Ray		16. SIGNATURE OF PHYSICIAN Dr. J. H. Hume	
17. SIGNATURE OF CORONER J. H. Hume		18. SIGNATURE OF JURY J. H. Hume	
19. SIGNATURE OF REGISTRAR J. H. Hume		20. SIGNATURE OF CLERK J. H. Hume	

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>P. H.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>41 Mt. Rainier</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges Hospital</i>		d. STREET ADDRESS <i>4114 33rd St</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Cassia ADAMS Jackson</i>		4. DATE OF DEATH Month Day Year <i>1-15-1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/14/86</i>
9. AGE (In years last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Bright, Virginia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Thomas T. Adams</i>		14. MOTHER'S MAIDEN NAME <i>Eliza Overstreet</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>227-52-8181</i>	
17. INFORMANT <i>Hawley E. Jackson</i>		Address <i>Mt. Rainier -4114- 33 St. Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <i>Coronary thrombosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>2 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JAN 10</i> , 19 <i>60</i> , to <i>JAN 15</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>JAN 15</i> , 19 <i>60</i> , and that death occurred at <i>405 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Leon R. Levitsky</i>		ADDRESS (Street, city or town, state) <i>3408 Rhode Island Ave. Mt. Rainier, Md.</i> DATE SIGNED <i>1/15/60</i>	
PHYSICIAN'S NAME (Type) <i>LEON R. LEVITSKY</i>		3408 RHODE ISLAND AVE./MD. <i>1/15/60</i>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>1/16/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Green Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Alta Vista, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S. L. Jones Co</i>		24a. REC'D BY REGISTRAR <i>2401-146</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

1

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



CERTIFICATE OF DEATH

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words are difficult to decipher but appear to include:]*

*[Name]*  
*[Address]*  
*[City]*  
*[State]*  
*[Date]*  
*[Signature]*  
*[Official Title]*



## CERTIFICATE OF DEATH

Reg. Dist. No.

01048

1025

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>				c. LENGTH OF STAY IN 1b <b>13 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>I</b> Last <b>Jackson</b>				4. DATE OF DEATH Month <b>1</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-20-98</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>0</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Naval gun Factory</b>			
13. FATHER'S NAME <b>William H. Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>218 16 0679</b>			
17. INFORMANT <b>Thomas Jackson</b>				Address <b>Upper Marlboro, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Disease</b> <b>443X</b> DUE TO <b>Hypertension and Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>1-13</b> , 19 <b>60</b> , to <b>1-26</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-26</b> , 19 <b>60</b> , and that death occurred at <b>11:15 PM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. D. BAKER, M.D.</b>				ADDRESS (Street, city or town, state) <b>Prince Georges General Hospital, Cheverly, Md.</b>			
DATE SIGNED <b>1/29/60</b>							
PHYSICIAN'S NAME (Type) <b>R. D. BAKER, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1-30-60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>St. Carmel</b>				22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kline</b>				24a. REC'D BY REGISTRAR <b>FEB 1 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

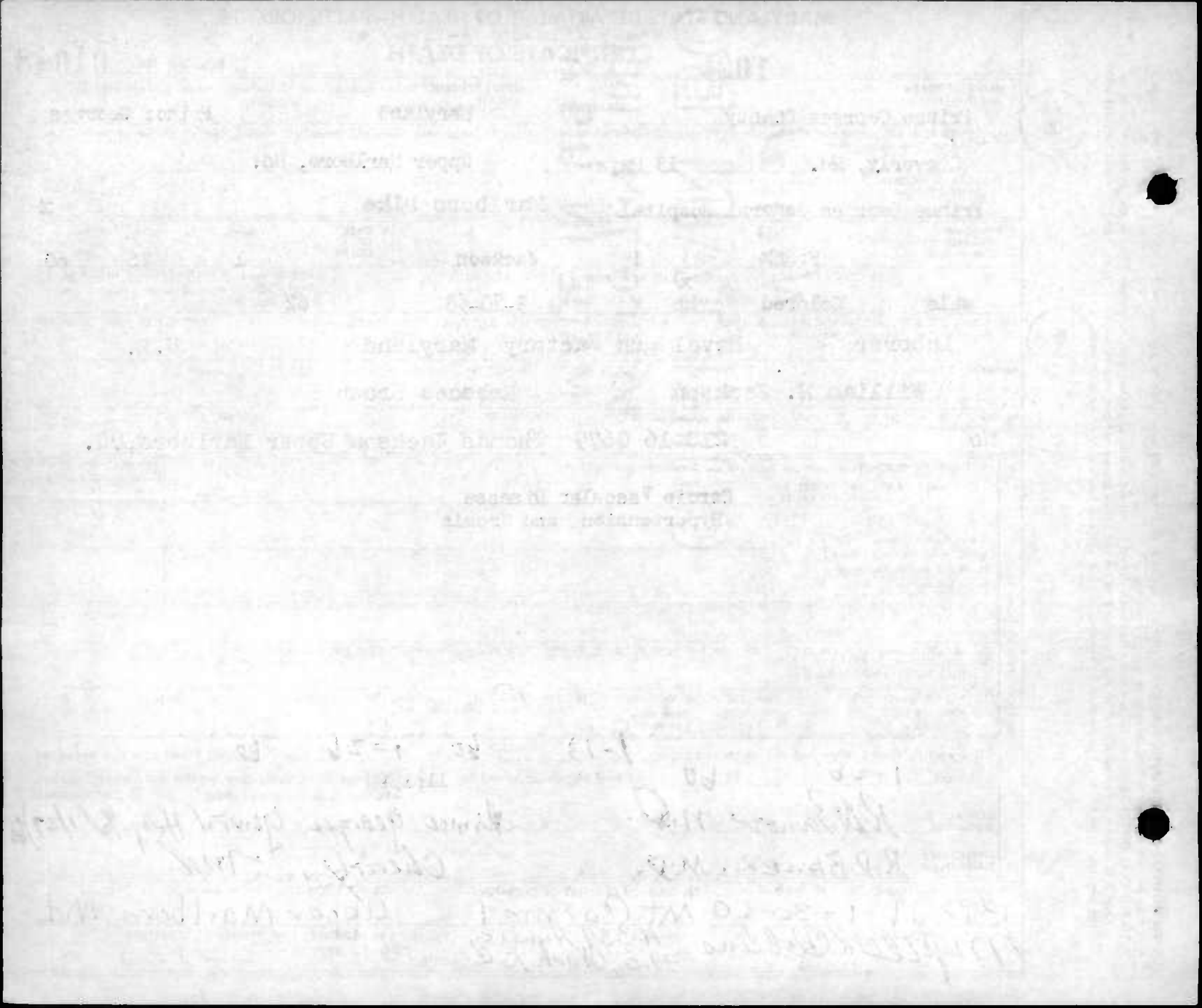
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 1106 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges, MARYLAND</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr. Geo.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cannondale Hills</i>				c. LENGTH OF STAY IN 1b <i>32 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>500-72nd Place</i>				d. STREET ADDRESS <i>500-72nd Place</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>GEORGE EDWARD JACOBS</i>				4. DATE OF DEATH Month Day Year <i>January 27 1960</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 14, 1879</i>	9. AGE (In years lost birthday) yrs. <i>80</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Builder</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Homes</i>		11. BIRTHPLACE (State or foreign country) <i>Alleghen Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>WM. JUDSON JACOBS</i>				14. MOTHER'S MAIDEN NAME <i>CORNELIA ALTHEA JENNINGS</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>		INFORMANT <i>Mrs. D. E. Jacobs</i>		Address <i>500-72nd Pl. Cannondale Hills</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease 20 years</i> DUE TO (c) <i>Asthma with Pulmonary Emphysema 20 years</i>						INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>January 15, 1941</i> , to <i>January 27, 1960</i> that I last saw the deceased alive on <i>January 10, 1960</i> , and that death occurred at <i>6:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>William Brainin M.D. 6124 Central Ave 1/27/60</i>							
ACTUAL SIGNATURE <i>William Brainin</i>		PHYSICIAN'S NAME (Type) <i>WM BRAININ Capital Heights Md</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>1-30-60</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>WASH NATIONAL</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home</i>				ADDRESS <i>300-4th St WASH DC</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 29 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1102

THE CITY OF NEW YORK



IN SENATE

JANUARY 1881

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1880

ALBANY: J. B. LIPPINCOTT & CO. 1881

NEW YORK: J. B. LIPPINCOTT & CO. 1881

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1060 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01050

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maine</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairfield</u> <u>57X-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7726 Kepling Parkway</u>				d. STREET ADDRESS <u>45 main street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Erling</u> Middle <u>Jonassen</u> Last <u>Jonassen</u>				4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 9, 1887</u>		9. AGE (In years last birthday) <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>Norway</u>	
13. FATHER'S NAME <u>Andreas Jonassen</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Andrea Larson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>06-10-5149</u>		17. INFORMANT <u>Mrs. Doris Poulin, same as #1</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute congestive heart failure</u> DUE TO (b) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>James I. Boyd</u> DATE SIGNED <u>May 20, 1960</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>1-23-1960</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Maplewood</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfield Maine</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Mattingly</u>				ADDRESS <u>131-11-11-11</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





1073

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>65 Riverdale</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eugene Leland Memorial Hospital</b>				e. STREET ADDRESS <b>6106 44th Pl.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>WILBUR</b> Last <b>JONES</b>				4. DATE OF DEATH Month <b>January</b> Day <b>4</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-23-81</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Am. Security &amp; Trust</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Louis Jones</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578 10 7056</b>		17. INFORMANT <b>Hospital Record</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized bleeding</b> <b>292.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Pancytopenia</b> DUE TO (c) <b>Etiology undetermined</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>59</b> , to <b>Jan 4</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 3</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Riverdale, Md.</b> DATE SIGNED <b>1-4-60</b> ACTUAL SIGNATURE <b>LW Malin</b> M.D. PHYSICIAN'S NAME (Type) <b>Lawrence W. Malin, M. D., 4404 Queensbury Rd., Riverdale, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/7/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 1107 CERTIFICATE OF DEATH

Reg. Dist. No.

01052

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION --		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Clark</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1870</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeping</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Claytor Jones</b>		14. MOTHER'S MAIDEN NAME <b>Frances Clark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. --	
17. INFORMANT <b>Miss Annie Jones-Mitchellville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>293X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congenital Heart Failure</b> (c) <b>Secondary Anemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>1 year</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> No while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 2, 1959</b> , to <b>Jan 20, 1960</b> , that I last saw the deceased alive on <b>Jan 6, 1960</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>James E. Sasser</b> M.D.		<b>Upper Marlboro, Md 1-21-60</b>	
PHYSICIAN'S NAME (Type) <b>James E. Sasser M.D.</b>		<b>Upper Marlboro Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/23/60:</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Barnabas Cem:</b>	22d. LOCATION (City, town, or county) (State) <b>Leeland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Upper Marlboro, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 26 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1102

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BATHING 10

Married

John Doe

Age

100

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

1/23/50

John Doe

John Doe

John Doe

John Doe

## 1026 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Madge (Emerline) E. Jordan				4. DATE OF DEATH Month Day Year Jan. 24 19 60			
5. SEX Female		6. COLOR OR RACE White		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-28- 82	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		11. BIRTHPLACE (State or foreign country) Pittsfield, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Ives				14. MOTHER'S MAIDEN NAME Mary Norton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. 286-18-8199			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. INTERVAL BETWEEN ONSET AND DEATH 48 hr. 15 yr.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from Jan. 22, 1960, to Jan. 24, 1960 that I last saw the deceased alive on Jan. 24, 1960, and that death occurred at 8:50 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. D. Baker M.D.				ADDRESS (Street, city or town, state) 2513 Buck Lodge Rd. DATE SIGNED 1-24-60			
PHYSICIAN'S NAME (Type) R. D. Baker, M.D.				M.D. Annapolis Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26, 1960		22c. NAME OF CEMETERY OR CREMATORY South Cemetery		22d. LOCATION (City, town, or county) (State) Rt. 58, Oberlin, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 5201-Cleveland Ave.				ADDRESS Riverdale Md.		24a. REC'D BY REGISTRAR JAN 27 '60	
				24b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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Item 18 Film 255 1-27-60 ams									
1027 CERTIFICATE OF DEATH									
Reg. Dist. No. 01054									
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					c. LENGTH OF STAY IN 1b <b>21 days</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>v.</b> Last <b>Kane</b>					4. DATE OF DEATH Month <b>Jan.</b> Day <b>14</b> Year <b>1960</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Unknown.</b>		9. AGE (In years lost birthday) <b>68</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>William F. Sinclair</b>					14. MOTHER'S MAIDEN NAME <b>Unknown.</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
INFORMANT <b>Grace E. Burns.</b> Address <b>Baltimore Md</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X POSS C.V.A.</b> DUE TO <b>(Cerebro vascular accident)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH <b>21 days</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>Dec. 24, 1959</b> to <b>Jan. 14, 1960</b> that I last saw the deceased alive on <b>Jan. 14, 1960</b> and that death occurred at <b>11:25 AM</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Benjamin J. Miller</b> M.D.					ADDRESS (Street, city or town, state) <b>3824-34 ST MT. RAINIER</b>				
DATE SIGNED <b>1/15/60</b>									
PHYSICIAN'S NAME (Type) <b>T. E. Costello</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>Jan. 16-1960</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>					22d. LOCATION (City, town, or county) (State) <b>Wash. D. C.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>T. E. Costello</b>					24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>				
ADDRESS <b>1722-N. CAP ST.</b>					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>				

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7,9 FilmG258 3-7-60 et

1028

CERTIFICATE OF DEATH

Reg. Dist. No.

01055

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 Hr</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>71 College Park</b> d. STREET ADDRESS <b>7512 Creighton Dr.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>George E. Brown Keaton</b>				4. DATE OF DEATH Month Day Year <b>Jan. 29 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/27/1904</b>	
9. AGE (In years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Repair man for office machinery</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>			
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>George W. Brown</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth J. Kaldenbach</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>575-20-0462</b>			
17. INFORMANT <b>Mrs. Thelma K. Staats, Sister</b>				Address <b>above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anteriosclerotic heart disease</b> DUE TO (c) <b>Anteriosclerotic heart disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Carcinoma of stomach 2. Aneurysm of abdominal aorta</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>9:05 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David S. Clayman M.D.</b>				ADDRESS (Street, city or town, State) <b>6211 Baltimore Road, Md.</b>			
DATE SIGNED <b>1/29/60</b>							
PHYSICIAN'S NAME (Type) <b>Dr. David S. Clayman M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Feb. 1/60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>				22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Valley Funeral Home</b>				ADDRESS <b>3200 Rhode Island Ave. N.W. Rainee, Md.</b>			
24a. REC'D BY REGISTRAR <b>4 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION

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CENTRAL BANK OF DEUTSCHLAND

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## 1029 CERTIFICATE OF DEATH

Reg. Dist. No.

01056

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>62 Hyattsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>4107 Oliver St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sadie</b>		First Middle Last <b>Kline</b>		4. DATE OF DEATH Month Day Year <b>Jan. 19 1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1889</b>		9. AGE (In years lost birthday) <b>70 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>LEBANON PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>REUBEN BLEISTINE DECEASED</b>				14. MOTHER'S MAIDEN NAME <b>MARY ELLEN KINGSBORO DECEASED</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>HARRY W. KLINE 4107 OLIVER ST. HYATTSVILLE MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>12 hrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Embolus Occlusion Left Femoral Artery &amp; Gangrene Left Leg</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Aug.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 16</b> , 19 <b>60</b> , to <b>Jan. 19</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Jan 19</b> , 19 <b>60</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm. A. Holbrook</b>		M.D.		ADDRESS (Street, city or town, state) <b>4500 College Ave., College Park, Md.</b>		DATE SIGNED <b>1/19/60</b>	
PHYSICIAN'S NAME (Type) <b>Wm. A. Holbrook, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JANUARY-22-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH CO. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John D. East</b>		ADDRESS <b>BOONSBORO MD</b>		24a. REC'D BY REGISTRAR <b>JAN 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100  
CERTIFICATE OF DEATH



THIS IS TO CERTIFY that on the \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_ at \_\_\_\_\_ in the \_\_\_\_\_ District of \_\_\_\_\_ New Zealand

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01057

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>200</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp</u>				d. STREET ADDRESS <u>15015 4 Roanoke Pl</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Mae</u> Last <u>Krause</u>				4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-2-1900</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Edw. Dwyer</u>		14. MOTHER'S MAIDEN NAME <u>Helen May Page</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-1978</u>		17. INFORMANT <u>Paul Bicknith</u> Address <u>Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x Acute congestive heart failure</u> DUE TO (b) <u>Coronary artery disease</u> DUE TO (c) <u>Coronary artery disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney - M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Any Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witt Randolph</u>				24a. REC'D BY REGISTRAR <u>Jan 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01058

1108

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's Co.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland, Maryland</b> c. LENGTH OF STAY IN 1b <b>2- Years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suitland Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>2400- 36th Street S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MOLLIE</b> First <b>T.</b> Middle <b>Lo</b> Last <b>BLANC</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>31st.</b> Year <b>19 60</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4- 1875</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months <b>84</b>	IF UNDER 24 HRS. Days <b>31st.</b> Hours <b>19</b> Min. <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Titusville, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>James Tuite</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ryan</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>Suitland Nursing Home</b> Address <b>Same As # 1.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332x Cerebral Thromboses</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>10 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 28, 1960</b> to <b>Jan 31, 1960</b> , that I last saw the deceased alive on <b>Jan 31, 1960</b> , and that death occurred at <b>9:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5558 Silver Hill Rd Wash DC</b> DATE SIGNED <b>Feb 1, 1960</b>						
ACTUAL SIGNATURE <b>Thomas F. Cleary</b>		PHYSICIAN'S NAME (Type) <b>THOMAS F. CLEARY</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CRYPTORY		22d. LOCATION (City, town, or county) (State)
<b>Burial Feb 3-60</b>		<b>Feb 3-60</b>		<b>St. Vincent Cemetery</b>		<b>New Orleans, Louisiana.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sammons Buss</b>		ADDRESS <b>1641- 9th Paper Rd SE</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>

# 1108 CERTIFICATE OF DEATH

John Doe, 1000

John Doe, 1000

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

*Item 13, Filed 4-347-1/29/64 cas*

1003

## CERTIFICATE OF DEATH

01059

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u> c. LENGTH OF STAY IN 1b <u>45 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4401 41st Street</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges'</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>46 Brentwood</u> d. STREET ADDRESS <u>14401 41st Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>Georgia</u> First <u>Laura</u> Middle <u>Lee</u> Last		<b>4. DATE OF DEATH</b> Month <u>JAN</u> Day <u>11</u> Year <u>1960</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>MAY 30 1879</u>		<b>9. AGE</b> (In years last birthday) <u>80</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>house wife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MD</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>USA</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>Thomas Walter JAMES RUSSELL Smoot</u>								<b>14. MOTHER'S MAIDEN NAME</b> <u>Ann Sophronia Cox</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>				<b>INFORMANT</b> Address <u>Newman S Lee Sr Avondale, Md.</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>334X</u> IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO <u>generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 yrs</u> DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>																	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>60</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that</b> <u>Norman Donat Comeau</u> attended the deceased from <u>March</u> , 19 <u>51</u> , to <u>1/11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/11</u> , 19 <u>60</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3503 Perry St</u> DATE SIGNED <u>1/11/60</u> ACTUAL SIGNATURE <u>Norman Donat Comeau</u> M.D. <u>MT Rainier MD</u> PHYSICIAN'S NAME (Type) <u>Norman Donat Comeau</u>																	
<b>22a. BURIAL, CREMATION, or other disposal</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Jan 14, 1960</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Suitland, Md.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>								<b>24a. REC'D BY REGISTRAR</b> DATE <u>JAN 14 '60</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

© 1914 J. M. L. Co.

James M. L.

NOTED: You are the only person who has been able to do this.

James M. L. Co.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0992

## CERTIFICATE OF DEATH

01060

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Pr. Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Pr Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>905 Ray Road</u>		d. STREET ADDRESS <u>1905 Ray Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Eliza Hopkins Love</u>		4. DATE OF DEATH <u>Jan 12 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>23 Apr 1880</u>
9. AGE (in years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Howard W Hopkins</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Francis Harding</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Min. S. E Love</u>	
17. INFORMANT <u>Min. S. E Love</u>		Address <u>905 Ray Rd Takoma Park, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cornary Occlusion</u> (c) <u>Chronic Myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> <u>Aug 17 1959</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Trig Attracting Vent. Tachycardia since Aug 1959</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street/office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/29</u> , 19 <u>59</u> , to <u>1/12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/10</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard T. Morse</u> M.D.		ADDRESS (Street, city or town, state) <u>7030 Carroll Ave</u>	
PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>		DATE SIGNED <u>1/12/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/15/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Burtonsville, Montgomery Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>JAN 15 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

023

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1880		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. COLOR White	
11. DECEASED AT Home		12. PLACE OF DEATH Home		13. DATE OF DEATH 1945		14. TIME OF DEATH 10:30 AM		15. CAUSE OF DEATH Heart Disease	
16. DISEASE OR INJURY Heart Disease		17. PERIOD OF ILLNESS Several weeks		18. PRESENT ILLNESS Angina pectoris		19. PREVIOUS ILLNESSES Hypertension		20. MEDICAL HISTORY None	
21. SIGNATURE OF PHYSICIAN J. H. Harris		22. SIGNATURE OF DECEASED J. H. Harris		23. SIGNATURE OF WITNESSES J. H. Harris		24. SIGNATURE OF CLERK J. H. Harris		25. SIGNATURE OF REGISTRAR J. H. Harris	

## 0999 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>				c. LENGTH OF STAY IN 1b <u>8 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4514-32<sup>nd</sup> Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Francis A. Lowe</u>				4. DATE OF DEATH <u>Jan. 19 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/9/1868</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist, Ret. Drugs</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Richmond, Va.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Adolph Lowe</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Von Strick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>068-26-2385</u>			
17. INFORMANT <u>Florence C. Lowe</u>				Address <u>above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>36 hrs</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1956</u> to <u>Jan 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 18</u> , 19 <u>60</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3824-34 ST</u> DATE SIGNED <u>1-19-60</u>							
ACTUAL SIGNATURE <u>Benjamin L. Miller</u> M.D.				PHYSICIAN'S NAME (Type) <u>BENAMIN S. MILLER</u> <u>Mt Rainier Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/21/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>				22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walleys Funeral Home, Inc.</u>				24a. REC'D BY REGISTRAR <u>DATE JAN 22 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiang</u>							

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO THE HONORABLE SECRETARY OF AGRICULTURE  
WASHINGTON, D. C.

SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the application for a patent for the invention of a new and improved method of growing plants in water.

The Bureau of Plant Industry has been advised of the application and is now conducting a preliminary investigation of the same. It is the policy of the Department to grant patents for inventions which are new, useful, and non-obvious.

I am, Sir, very respectfully,  
Yours very truly,  
J. H. H. H.

1

1109

1062

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>				c. LENGTH OF STAY IN 1b <b>25 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>130 East 11th. St.</b>				d. STREET ADDRESS <b>130 East 11th. Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>BERNARD VOSS LUERS</b>				4. DATE OF DEATH <b>Jan. 13 19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 Nov. 1893</b>		9. AGE (In years birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tet. Groceries</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank B. Luers</b>				14. MOTHER'S MAIDEN NAME <b>Maggie A. Disney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, No, war or dates of service) <b>216-32-6910</b>		17. INFORMANT <b>Marian C. Luers Same as # 2 (Wife)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EMPHYSEMA-STAPH-PNEUMONIA</b> DUE TO <b>1 YR.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fibrotic PULM. TBC.</b> <b>20 YRS.</b> (c) <b>GEN. ARTERIO SCLEROSIS</b> <b>20 YRS.</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/21, 1938</b> , to <b>1/13, 1960</b> , that I last saw the deceased alive on <b>1/93, 1960</b> , and that death occurred at <b>5:45 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. M. Warren</b> M.D.				ADDRESS (Street, city or town, state) <b>Laurel, Maryland</b>		DATE SIGNED <b>1/13/60</b>	
PHYSICIAN'S NAME (Type) <b>G. M. WARREN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



## 1063 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Heights</b>				c. LENGTH OF STAY IN 1b <b>10 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>44 25 Panarama Drive</b>				d. STREET ADDRESS <b>4425 Panarama Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle Last <b>Lumb</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>31</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 12, 1883</b>	
9. AGE (In years lost birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Ezra Brooks</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Greenwood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mrs. Ralph G. McIntyre</b>				<b>4425 Panarama Dr. Forest Hgts.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Febr. 2</b> , 19 <b>59</b> , to <b>Jan 31</b> , 19 <b>60</b> , that I lost saw the deceased alive on <b>1/29</b> , 19 <b>60</b> , and that death occurred at <b>9 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Etienne Heller</b>				ADDRESS (Street, city or town, state) <b>2. Parkway Drive</b>			
PHYSICIAN'S NAME (Type) <b>ETIENNE Szollosi</b>				DATE SIGNED <b>Forest Hgts. (Md)</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				22b. DATE THEREOF <b>Feb. 1 1960</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Lees Crematory</b>				22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>				ADDRESS <b>300 4th St. Wash D.C.</b>			
24a. REC'D BY REGISTRAR <b>FEB 3 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10.3 CERTIFICATE OF DEATH

PAINTER GEORGE      MARYLAND      WITNESS GEORGE

Forest Heights      10 years      Forest Heights

44 25 Pennamond Drive

4425 Pennamond Drive

Female White

Nov. 12, 1967

Monticello

England

Birth records

Barter Greenwood

None

No

Mrs. John G. Marysville Forest Heights

Registration No. 1007 1967 used Greenway

01064

**ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>12 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>63 RENEWED Hyattsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>14300 Emerson Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Thomas</b>		Middle <b>M</b>		Last <b>Lynch</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. <del>MARRIED</del> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 Feb 1879 1880</b>	
9. AGE (In years last birthday) <b>80 79 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>New York City, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Thomas Joseph Lynch</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Mc Govern</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>Mrs. Lillian L. Allen</b> <b>4300 Emerson St. Hyattsville, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b> <b>2 weeks</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>OCT 1959</b> , to <b>JAN 24, 1960</b> , that I last saw the deceased alive on <b>JAN 23, 1960</b> , and that death occurred <b>4:50 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman D. Comeau</b>		M.D.		ADDRESS (Street, city or town, state) <b>3503 Penny St</b>		DATE SIGNED <b>1/24/60</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Norman Comeau, M.D.</b>		<b>Mt. Rainier, Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/27/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Arlington, Virginia</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>mt. Rainier, Md</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Claudia L. Thomas</b>	

STATE OF TEXAS

100



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1032 CERTIFICATE OF DEATH

01065

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2601 Cheverly Ave</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Beaver Heights</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>11406-49th Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY C</u> First Middle Lost		4. DATE OF DEATH <u>January 28</u> Month Day Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired desk clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus Malsberger</u>		14. MOTHER'S MAIDEN NAME <u>Belle Scotten</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-03-5243</u>	
17. INFORMANT <u>Agnes M. Huggins</u> Address <u>1530 Albee Street N.E. Wash D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.C. Congestive Heart Disease</u> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardior Pulmonary Disease</u> DUE TO (c) <u>Chronic Emphysema</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 28, 1955</u> to <u>Jan 28, 1960</u> , that I last saw the deceased alive on <u>Jan 28, 1960</u> , and that death occurred at <u>11:45 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard Katzen</u>		ADDRESS (Street, city or town, state) <u>3550 Wisconsin Ave. S.E. Wash D.C.</u> DATE SIGNED <u>1-29-60</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD KATZEN M.D.</u>		<u>3550 Wisconsin Ave. S.E. Wash D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/1/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Southland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Leary Sons Co</u> ADDRESS <u>3605-14 St NW Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>FEB 1 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>JOHN C. HARRIS</b>		2. SEX <b>MALE</b>	
3. AGE <b>64</b>		4. RACE <b>WHITE</b>	
5. DATE OF DEATH <b>1946-01-10</b>		6. TIME OF DEATH <b>10:00 AM</b>	
7. PLACE OF DEATH <b>HOME</b>		8. STREET ADDRESS <b>1000 N. E. ST.</b>	
9. CITY <b>BALTIMORE</b>		10. COUNTY <b>JOHNS HOPKINS</b>	
11. STATE <b>MARYLAND</b>		12. ZIP CODE <b>21205</b>	
13. OCCUPATION <b>RETIRED</b>		14. CAUSE OF DEATH <b>HEART DISEASE</b>	
15. MANNER OF DEATH <b>NATURAL</b>		16. SIGNATURE OF PHYSICIAN <b>[Signature]</b>	
17. SIGNATURE OF DECEASED <b>[Signature]</b>		18. SIGNATURE OF WITNESS <b>[Signature]</b>	
19. SIGNATURE OF REGISTRAR <b>[Signature]</b>		20. SIGNATURE OF CLERK <b>[Signature]</b>	

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. RACE  
5. DATE OF DEATH  
6. TIME OF DEATH  
7. PLACE OF DEATH  
8. STREET ADDRESS  
9. CITY  
10. COUNTY  
11. STATE  
12. ZIP CODE  
13. OCCUPATION  
14. CAUSE OF DEATH  
15. MANNER OF DEATH  
16. SIGNATURE OF PHYSICIAN  
17. SIGNATURE OF DECEASED  
18. SIGNATURE OF WITNESS  
19. SIGNATURE OF REGISTRAR  
20. SIGNATURE OF CLERK



1 ~~X~~  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1110 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01066

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradbury Heights</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 Bradbury Heights</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>513 T Street</b>		d. STREET ADDRESS <b>513 T Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BRADLEY</b> Middle <b>(NMN)</b> Last <b>MANDLEY</b>		4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 27, 1894</b>
9. AGE (in years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>578-36-3222</b>	17. INFORMANT <b>Mrs. Clara I. Mandley, Bradbury Hgts. Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> <b>Acute congestive heart failure</b> DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		<b>January 2, 1960.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 6, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO., 517 11th St., S./E.</b>		24a. REC'D BY REGISTRAR <b>JAN 7 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>	

352 J. S. Hwang and S. H. Kim

## 1111 CERTIFICATE OF DEATH

Reg. Dist. No.

01067

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b> <b>08X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Dobson Clinic</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Wayne Allen Marshall</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 7 1958</b>
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR: Months <b>3</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert Brown</b>	
14. MOTHER'S MAIDEN NAME <b>Joyce Marshall</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT Address <b>Joyce Marshall, Waldorf, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>053.4</b> DUE TO <b>conwelling Septis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Septicemia</b> DUE TO <b>Septicemia</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-12</b> , 19 <b>60</b> , to <b>1-14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-14</b> , 19 <b>60</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brandywine, Md.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>Joyce Marshall</b> M.D. <b>Brandywine, Md.</b> PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-16-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Peters</b>	22d. LOCATION (City, town, or county) (State) <b>Waldorf, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '60</b>	24b. REGISTRAR'S SIGNATURE <b>C. J. Hunter</b>

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

1911

James C. ...  
Evangeline ...  
Dorothy ...  
William ...  
Milo ...  
Robert ...  
Mrs. ...

...

1-14  
Evangeline, md

1074

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clara J. Martin</u>				4. DATE OF DEATH Month Day Year <u>January 29 1960</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10-1877</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Mackabee</u>				14. MOTHER'S MAIDEN NAME <u>Ann Duval</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Daughter Clara T Martin Rt#1 Box 101</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-19</u> , 19 <u>59</u> , to <u>1-29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-28</u> , 19 <u>60</u> , and that death occurred at <u>3:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>D.R. Purdie</u> M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>D.R. PURDIE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/1/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. W. Caldwell</u> ADDRESS <u>Laurel Md.</u>				24. REC'D BY REGISTRAR <u>FEB 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Schmitt</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01069

1112

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>31 HOURS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORESTVILLE 21</b> d. STREET ADDRESS <b>8302 Beltz Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NEWBORN</b> Middle <b>Dorothy Ann</b> Last <b>MARTIN</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 JANUARY 1960</b>
9. AGE (In years last birthday) <b>1</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>CHARLES ALLEN MARTIN</b>		14. MOTHER'S MAIDEN NAME <b>MONIQUE PRADERE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>CHARLES A MARTIN (F)</b>		18. ADDRESS (Street, city or town, state) <b>8302 Beltz Drive Forestville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY DISEASE OF NEWBORN</b> 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PREMATURITY</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>31 HOURS</b> <b>31 HOURS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>23 JANUARY, 1960</b> , to <b>24 JANUARY, 1960</b> , that I last saw the deceased alive on <b>24 JANUARY, 1960</b> , and that death occurred at <b>1305P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>ANDREWS AIR FORCE BASE 24 JANUARY 1960</b>			
ACTUAL SIGNATURE <b>Arnold A. Abramo</b>		M.D. <b>ANDREWS AIR FORCE BASE</b>	
PHYSICIAN'S NAME (Type) <b>ARNOLD A ABRAMO, CAPT, USAF, MC</b>		<b>USAF HOSPITAL ANDREWS, WASHINGTON 25, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/27/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Michael S. Rinaldi</b> <b>Rinaldi Funeral Home, Inc. 816 H St., N.E., DC2</b>		24a. REC'D BY REGISTRAR <b>JAN 27 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Crispin S. Thomas</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5000233XV2



## CERTIFICATE OF DEATH

Reg. Dist. No.

01070

1033

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 Day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> d. STREET ADDRESS <b>4200 28th St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>(Baby Girl B) Diane C. McDonough</b>		4. DATE OF DEATH <b>Jan. 5</b>		Month <b>5</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 4, 1960</b>		9. AGE (In years last birthday) <b>—</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank E</b>		14. MOTHER'S MAIDEN NAME <b>Grace M Cacchione</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Mother</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYALINE MEMBRANE DISEASE</b> 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>PREMATURITY</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b> <b>LIFE.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Jan. 4</b> , 19 <b>60</b> , to <b>Jan 5</b> , 1960, that I last saw the deceased alive on <b>Jan. 5</b> , 19 <b>60</b> , and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Joseph McDonald</b>		ADDRESS (Street, city or town, state) <b>7309 RIGGS RD. HYATTSVILLE, MD.</b>		DATE SIGNED <b>1/6/60</b>	
PHYSICIAN'S NAME (Type) <b>Joseph McDonald</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/6/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Washington</b>		(State) <b>D. C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		24a. RECEIVED BY REGISTRAR <b>JAN 7 1960</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

22 77192XVI

CERTIFICATE OF DEATH

1005

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 15, 1900*

5. Place of birth: *New York City*

6. Date of death: *Dec 10, 1945*

7. Place of death: *Home*

8. Cause of death: *Heart Disease*

9. Signature of physician: *[Signature]*

10. Signature of registrar: *[Signature]*

11. Date of registration: *Dec 15, 1945*

12. Office of registration: *New York City*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01071

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u> c. LENGTH OF STAY IN 1b <u>49 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Middleton Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u> d. STREET ADDRESS <u>Middleton Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Alexander</u> Middle <u>Middleton</u> Last <u>Middleton</u> <b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>7</u> Year <u>1960</u>			<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Sept 28, 1911</u> <b>9. AGE</b> (In years last birthday) <u>48</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>farmer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>general</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>				
<b>13. FATHER'S NAME</b> <u>Alexander Middleton</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Gertrude Underwood</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>217-34-0078</u> <b>17. INFORMANT</b> <u>Mrs. Mary Middleton, same as #1</u> Address <u>same as #1</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x Acute congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a. m. _____ p. m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____					
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>James T. Boyd</u> <b>EXAMINER'S NAME (Type)</b> <u>James T. Boyd</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>Jan 7, 1960</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>Jan. 11, 1960</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Washington National</u> <b>22d. LOCATION (City, town, or county)</b> <u>Suitland, Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Huxtt Funeral Home, Waldorf, Md.</u> <b>ADDRESS</b> _____ <b>24a. REC'D BY REGISTRAR</b> _____ <b>DATE</b> <u>JAN 13 '60</u>					
<b>24b. REGISTRAR'S SIGNATURE</b> <u>James T. Boyd</u>		<b>24c. REGISTRAR'S SIGNATURE</b> _____					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME (Print or Type)		DATE OF BIRTH	
SEX		RACE	
EDUCATION		OCCUPATION	
MARRIED		SINGLE	
PREVIOUS MARRIAGES		PRESENT MARRIAGE	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		INJURY	
SYMPTOMS		TREATMENT	
HISTORY		FAMILY HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
TOPOGRAPHICAL FINDINGS		CYTOLOGICAL FINDINGS	
BACTERIOLOGICAL FINDINGS		SEROLOGICAL FINDINGS	
IMMUNOLOGICAL FINDINGS		GENETIC FINDINGS	
PSYCHOLOGICAL FINDINGS		SOCIAL FINDINGS	
LEGAL FINDINGS		OTHER FINDINGS	

Signature of Medical Examiner: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Place: \_\_\_\_\_



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01073

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <span style="float: right;">1035</span> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. State <b>Michigan</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairview</b> d. STREET ADDRESS <b>59x-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>DARREL</b> First <b>ROSS</b> Middle <b>MILLER</b> Last				<b>4. DATE OF DEATH</b> Month <b>Jan.</b> Day <b>1</b> Year <b>1960</b>											
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Nov. 27, 1935</b>		<b>9. AGE</b> (In years at birthday) <b>24</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Soldier</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Army</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Mich.</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Jesse Elvin Miller</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Lela Marie Gusler</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>Active</b>				<b>16. SOCIAL SECURITY NO.</b> <b>363 36 4467</b>				<b>17. INFORMANT</b> <b>Birth Certificate Found on Person</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severence of trachea with hemorrhage.</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Operator of an automobile in collision with another automobile</b>											
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>6.30</b> Hour <b>1-1-</b> Day <b>1960</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		<b>20f. (City or town)</b> <b>Muirkirk</b>		<b>(County)</b> <b>Pr. Geo.</b>		<b>(State)</b> <b>Md.</b>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checkbox"="" checked="" type="checkbox/&gt;, and find that death resulted from:&lt;/b&gt; Natural causes &lt;input type="/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> </b>															
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <b>1-1-60</b>							
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>				<b>22b. DATE THEREOF</b> <b>JAN. 7-1960</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Mio MICHIGAN</b>				<b>22d. LOCATION (City, town, or county)</b> <b>Michigan</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Risaldi Funeral Home 816 N. St. N.E. Wash, D.C.</i>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE JAN 7 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Evans</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased George Washington		Sex Male	
Age 65		Date of Birth Jan 1, 1880	
Place of Birth Baltimore, Md.		Usual Residence Baltimore, Md.	
Cause of Death Heart Disease		Manner of Death Natural	
Physician's Name Dr. J. H. Smith		Signature of Physician J. H. Smith	
Medical Examiner's Name Dr. A. B. Jones		Signature of Medical Examiner A. B. Jones	
Date of Examination Jan 15, 1945		Place of Examination Baltimore, Md.	
Signature of Coroner C. D. E.		Signature of Registrar F. G. H.	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1075 CERTIFICATE OF DEATH

Reg. Dist. No.

01074

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pro George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale Md</b>		c. LENGTH OF STAY IN 1b <b>10 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6319 1/2 Kenilworth avenue,.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>D.</b> Last <b>Moberley</b>		4. DATE OF DEATH Month <b>January</b> Day <b>5,</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb 13, 1869</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b>90</b> Days <b>90</b> Hours <b>90</b> Min.	IF UNDER 24 HRS. Months <b>90</b> Days <b>90</b> Hours <b>90</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William B Mobley</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Day</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>Anita Boyle</b>		Address <b>Riverdale, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>1-5-60</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hyattsville, Md.</b> DATE SIGNED <b>1-7-60</b> ACTUAL SIGNATURE <b>Leonard Hays</b> M.D. <b>Hyattsville, Md.</b> PHYSICIAN'S NAME (Type) <b>Leonard Hays</b> <b>Hyattsville Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/8/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Washington National</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1015 CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
RESIDENCE: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF DECEASED: [illegible]  
SIGNATURE OF WITNESS: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF MINISTER: [illegible]

1015 CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY Prince George's MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Maryland b. COUNTY Prince George's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. c. LENGTH OF STAY IN 1b 61 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 62 Hyattsville, Maryland.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4100 Emerson Street

d. STREET ADDRESS 4100 Emerson Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last Herbert John Moffat

4. DATE OF DEATH Month Day Year January 23, 19 60

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH June 24, 1872 9. AGE (In years lost birthday) yrs. 87 IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Builder

11. BIRTHPLACE (State or foreign country) Washington D. C. 12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME William Herbert Moffat

14. MOTHER'S MAIDEN NAME Susan Callan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no

INFORMANT Ruth H Moffat Address Hyattsville, Maryland.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Myocardial infarction

Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1959, to 1-23, 1960, that I last saw the deceased alive on 1-22, 1960, and that death occurred at 5:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE Leonard Hays M.D. 1

PHYSICIAN'S NAME (Type) Dr Leonard Hays Hyattsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/25/60 22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery 22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland. ADDRESS 24a. REC'D BY REGISTRAR DATE JAN 26 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Hays

1934 CERTIFICATE OF DEATH

AS A M. 1034

Name of Deceased		Date of Death	
Age		Sex	
Marital Status		Occupation	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01976

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <span style="float: right;">1036</span> MARYLAND			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md.</b>		c. LENGTH OF STAY IN lb <b>11 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>62 Hyattsville, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>4103 Farragut St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Margaret</b> Middle <b>Moore</b> Last			<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>29</b> Year <b>19 60</b>		
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>August 26, 1869</b>			<b>9. AGE</b> (In years last birthday) <b>90 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Philadelphia, Pa</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>			<b>13. FATHER'S NAME</b> <b>William H. Moore</b>		
<b>14. MOTHER'S MAIDEN NAME</b> <b>Eliza J. Walker</b>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <b>no</b>		
<b>16. SOCIAL SECURITY NO.</b> <b>none</b>			<b>17. INFORMANT</b> <b>William Moore</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO (b) <b>Fracture of left femur with hip nailing</b> DUE TO (c) <b>operation</b> FALL IN HOME.			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, senility.</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Fall in living room of home. ( Nursing Home)</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>10.30 a.m. Jan. 17 60</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Nursing Home</b>	
<b>20f. (City or town)</b> <b>Cheverly</b>		<b>(County)</b> <b>Pr. Geo.</b>		<b>(State)</b> <b>Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i>			<b>DATE SIGNED</b> <b>January 28, 1960</b>		
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Transportation 1/30/60</b>		<b>22b. DATE THEREOF</b> <b>1/30/60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Philadelphia</b>	
<b>22d. LOCATION (City, town, or county)</b> <b>Pennsylvania</b>		<b>22e. (State)</b>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F. Gasch's Sons</b>			<b>ADDRESS</b> <b>Hyattsville, Maryland.</b>		
<b>24a. REC'D BY REGISTRAR</b> <b>FEB 1 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kras</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1000

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. RAINIER</u>				c. LENGTH OF STAY IN 1b <u>1951</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4206 - Russell Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANN VERONICA MORRISSEY</u>				4. DATE OF DEATH Month Day Year <u>JAN 26 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 17, 1903</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BROOKLYN, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD McGRATH</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE McGLYNN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>133-18-3395</u>		INFORMANT <u>RICHARD MORRISSEY</u>		Address <u>MT RAINIER, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>203x MULTIPLE MYELOMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>8 MONTHS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 1</u> , 19 <u>59</u> , to <u>JAN 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JAN 26</u> , 19 <u>60</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel J. Sugar</u>		ADDRESS (Street, city or town, state) <u>4300 Kaywood Dr Jan 26 1960</u>					
PHYSICIAN'S NAME (Type) <u>SAMUEL J. N. SUGAR</u>		DATE SIGNED <u>MT RAINIER, MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 1 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased: JOHN J. HARRIS

2. Sex: Male

3. Age: 45

4. Date of Birth: 1915

5. Date of Death: 1960

6. Place of Death: Home

7. Cause of Death: Myocardial Infarction

8. Duration of Illness: 24 hours

9. Attending Physician: Dr. J. H. Harris

10. Place of Death: Home

11. Signature of Physician: [Signature]

12. Signature of Registrar: [Signature]

13. Date of Registration: 1960

## 1082 CERTIFICATE OF DEATH

Reg. Dist. No.

01978

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Park</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Park 64</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4308 Woodberry Street</b>			d. STREET ADDRESS <b>4308 Woodberry Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>C.</b> Last <b>MUHL</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>16</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 5, 1876</b>		9. AGE (In years last birthday) <b>83 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>John F. Zeller</b>			14. MOTHER'S MAIDEN NAME <b>Ann Holler</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	INFORMANT <b>Log Inn Road, Box 388</b> <b>Mr. D. Leroy Muhl-R.F.D. #2, Annapolis, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>1+ years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-15</b> , 19 <b>59</b> , to <b>1-16</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-15</b> , 19 <b>60</b> , and that death occurred at <b>3:50 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <b>Waldo B. Moyers</b>		M.D. <b>3503 Perry St</b>			
PHYSICIAN'S NAME (Type) <b>Waldo B. Moyers</b>		<b>Mt. Rainier, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/18/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. T. Coburn</b>		ADDRESS <b>Baltimore, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carroll S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

100 CERTIFICATE OF DEATH

IN THE COUNTY OF

STATE OF

CITY OF

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX



## CERTIFICATE OF DEATH

Reg. Dist. No.

01079

1037

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>11 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Katherine Lucinda Murphy</b>				4. DATE OF DEATH <b>Jan 27 19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 Oct. 1931</b>	
9. AGE (In years lost birthday) <b>28 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Burtonsville Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>			
13. FATHER'S NAME <b>James Dunall</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Poole</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANEMIA</b> 705.4 DUE TO <b>gLOMERULO - NEPHRITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Lupus ERYTHEMATOSIS</b> (c) <b>2 yrs</b> <b>3 yrs</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/16</b> , 19 <b>60</b> , to <b>1/27</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/27</b> , 19 <b>60</b> , and that death occurred at <b>2:15 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman Dene Comeau</b>				ADDRESS (Street, city or town, state) <b>3503 Long St.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Norman Comeau, M.D.</b>				DATE SIGNED <b>1/27/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Burtonsville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>De Witt Donaldson</b>				ADDRESS <b>313 Talbot St.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	
DATE <b>FEB 1 '60</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1076 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>155 Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hospital</u>				d. STREET ADDRESS <u>1 4802 Rittenhouse</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>PHILIP</u> Middle <u>DANIEL</u> Last <u>NAUGLE</u>		4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>19 60</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-26-84</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>DeWitt Naugle</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Beers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW1</u>		17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> <u>? 4 Year</u> (c) <u>Generalized Arteriosclerosis</u> <u>Years ??</u>							INTERVAL BETWEEN ONSET AND DEATH <u>28 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19, 1959</u> to <u>Jan. 26, 1960</u> , that I last saw the deceased alive on <u>Jan. 19, 1960</u> , and that death occurred at <u>7:50 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David S. Clayman</u> M.D.		ADDRESS (Street, city or town, state) <u>6311 Baltimore Ave - Riverdale Md</u> DATE SIGNED <u>1/26/60</u>					
PHYSICIAN'S NAME (Type) <u>David S. Clayman, M. D. 6311 Baltimore Ave., Riverdale, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. King</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  JAMES EARL RAY</p>		<p>2. SEX                  Male</p>		<p>3. AGE                  35</p>	
<p>4. DATE OF DEATH                  April 4, 1968</p>		<p>5. TIME OF DEATH                  11:00 AM</p>		<p>6. PLACE OF DEATH                  Room 306, Lorraine Motel, Memphis, Tennessee</p>	
<p>7. CAUSE OF DEATH                  Gunshot wound, self-inflicted</p>		<p>8. MANNER OF DEATH                  Suicide</p>		<p>9. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>10. DATE OF BIRTH                  March 21, 1933</p>		<p>11. TIME OF BIRTH                  1:00 PM</p>		<p>12. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>13. DATE OF DEATH                  April 4, 1968</p>		<p>14. TIME OF DEATH                  11:00 AM</p>		<p>15. PLACE OF DEATH                  Room 306, Lorraine Motel, Memphis, Tennessee</p>	
<p>16. CAUSE OF DEATH                  Gunshot wound, self-inflicted</p>		<p>17. MANNER OF DEATH                  Suicide</p>		<p>18. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>19. DATE OF BIRTH                  March 21, 1933</p>		<p>20. TIME OF BIRTH                  1:00 PM</p>		<p>21. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>22. DATE OF DEATH                  April 4, 1968</p>		<p>23. TIME OF DEATH                  11:00 AM</p>		<p>24. PLACE OF DEATH                  Room 306, Lorraine Motel, Memphis, Tennessee</p>	
<p>25. CAUSE OF DEATH                  Gunshot wound, self-inflicted</p>		<p>26. MANNER OF DEATH                  Suicide</p>		<p>27. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>28. DATE OF BIRTH                  March 21, 1933</p>		<p>29. TIME OF BIRTH                  1:00 PM</p>		<p>30. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>31. DATE OF DEATH                  April 4, 1968</p>		<p>32. TIME OF DEATH                  11:00 AM</p>		<p>33. PLACE OF DEATH                  Room 306, Lorraine Motel, Memphis, Tennessee</p>	
<p>34. CAUSE OF DEATH                  Gunshot wound, self-inflicted</p>		<p>35. MANNER OF DEATH                  Suicide</p>		<p>36. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>37. DATE OF BIRTH                  March 21, 1933</p>		<p>38. TIME OF BIRTH                  1:00 PM</p>		<p>39. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>40. DATE OF DEATH                  April 4, 1968</p>		<p>41. TIME OF DEATH                  11:00 AM</p>		<p>42. PLACE OF DEATH                  Room 306, Lorraine Motel, Memphis, Tennessee</p>	
<p>43. CAUSE OF DEATH                  Gunshot wound, self-inflicted</p>		<p>44. MANNER OF DEATH                  Suicide</p>		<p>45. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>46. DATE OF BIRTH                  March 21, 1933</p>		<p>47. TIME OF BIRTH                  1:00 PM</p>		<p>48. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>49. DATE OF DEATH                  April 4, 1968</p>		<p>50. TIME OF DEATH                  11:00 AM</p>		<p>51. PLACE OF DEATH                  Room 306, Lorraine Motel, Memphis, Tennessee</p>	
<p>52. CAUSE OF DEATH                  Gunshot wound, self-inflicted</p>		<p>53. MANNER OF DEATH                  Suicide</p>		<p>54. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>55. DATE OF BIRTH                  March 21, 1933</p>		<p>56. TIME OF BIRTH                  1:00 PM</p>		<p>57. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>58. DATE OF DEATH                  April 4, 1968</p>		<p>59. TIME OF DEATH                  11:00 AM</p>		<p>60. PLACE OF DEATH                  Room 306, Lorraine Motel, Memphis, Tennessee</p>	
<p>61. CAUSE OF DEATH                  Gunshot wound, self-inflicted</p>		<p>62. MANNER OF DEATH                  Suicide</p>		<p>63. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>64. DATE OF BIRTH                  March 21, 1933</p>		<p>65. TIME OF BIRTH                  1:00 PM</p>		<p>66. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>67. DATE OF DEATH                  April 4, 1968</p>		<p>68. TIME OF DEATH                  11:00 AM</p>		<p>69. PLACE OF DEATH                  Room 306, Lorraine Motel, Memphis, Tennessee</p>	
<p>70. CAUSE OF DEATH                  Gunshot wound, self-inflicted</p>		<p>71. MANNER OF DEATH                  Suicide</p>		<p>72. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>73. DATE OF BIRTH                  March 21, 1933</p>		<p>74. TIME OF BIRTH                  1:00 PM</p>		<p>75. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>76. DATE OF DEATH                  April 4, 1968</p>		<p>77. TIME OF DEATH                  11:00 AM</p>		<p>78. PLACE OF DEATH                  Room 306, Lorraine Motel, Memphis, Tennessee</p>	
<p>79. CAUSE OF DEATH                  Gunshot wound, self-inflicted</p>		<p>80. MANNER OF DEATH                  Suicide</p>		<p>81. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>82. DATE OF BIRTH                  March 21, 1933</p>		<p>83. TIME OF BIRTH                  1:00 PM</p>		<p>84. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>85. DATE OF DEATH                  April 4, 1968</p>		<p>86. TIME OF DEATH                  11:00 AM</p>		<p>87. PLACE OF DEATH                  Room 306, Lorraine Motel, Memphis, Tennessee</p>	
<p>88. CAUSE OF DEATH                  Gunshot wound, self-inflicted</p>		<p>89. MANNER OF DEATH                  Suicide</p>		<p>90. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>91. DATE OF BIRTH                  March 21, 1933</p>		<p>92. TIME OF BIRTH                  1:00 PM</p>		<p>93. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>94. DATE OF DEATH                  April 4, 1968</p>		<p>95. TIME OF DEATH                  11:00 AM</p>		<p>96. PLACE OF DEATH                  Room 306, Lorraine Motel, Memphis, Tennessee</p>	
<p>97. CAUSE OF DEATH                  Gunshot wound, self-inflicted</p>		<p>98. MANNER OF DEATH                  Suicide</p>		<p>99. PLACE OF BIRTH                  Jackson, Mississippi</p>	
<p>100. DATE OF BIRTH                  March 21, 1933</p>		<p>101. TIME OF BIRTH                  1:00 PM</p>		<p>102. PLACE OF BIRTH                  Jackson, Mississippi</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, MEMPHIS, TENNESSEE.

## CERTIFICATE OF DEATH

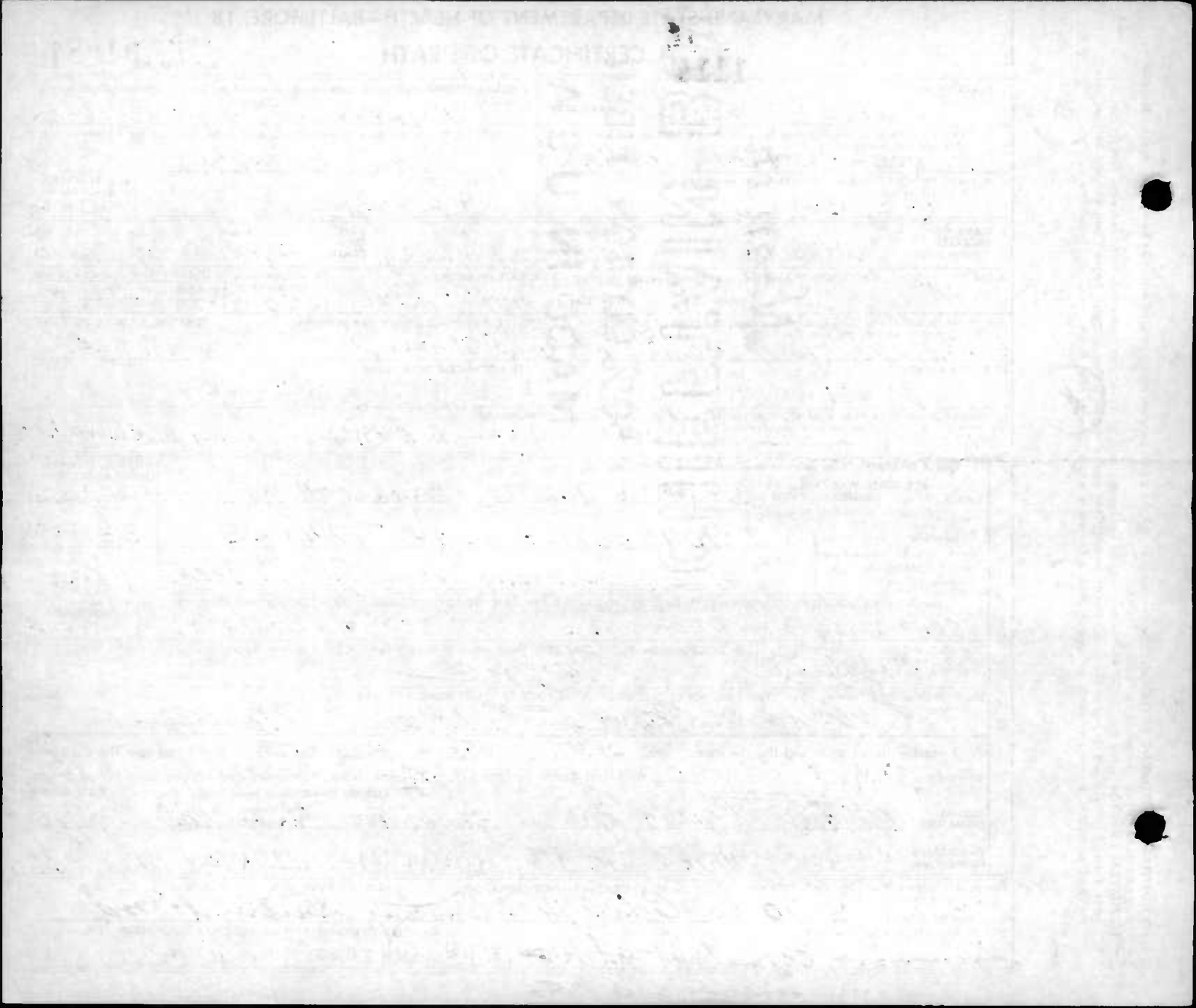
Reg. Dist. No. 01081

1114

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - CLINTON</b>		c. LENGTH OF STAY IN lb <b>48 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt 2 Box 211</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM SAMUEL NAYLOR</b>		4. DATE OF DEATH Month Day Year <b>JAN. 18 1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 28, 1887</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CRANE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT. CONSTRUCTION</b>	
11. BIRTHPLACE (State or foreign country) <b>AQUASCO, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CORNELIUS NAYLOR</b>		14. MOTHER'S MAIDEN NAME <b>SEWBY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>WIFE - ANITA NAYLOR - Rt 2 Box 211 CLINTON, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA DUE TO RENAL FAILURE</b> <b>442X</b> DUE TO (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA OF PROSTATE - LOCALIZED IN PROSTATE,</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS.</b> <b>3 1/2 wks.</b> <b>10 YRS.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>None</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>None</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>None</b>	
21. I certify that I attended the deceased from <b>SEPT. 1956</b> , to <b>present</b> , that I last saw the deceased alive on <b>JAN. 15, 1960</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Branch Ave. Clinton, Md. 1/13/60</b>			
ACTUAL SIGNATURE <b>Arthur Shaver Jr.</b> M.D.			
PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR. M.D. BRANCH AVE. CLINTON, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Jan 20-60</b>		22b. DATE THEREOF <b>Jan 20-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Southland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Remond Bros 1661-gd Hope Rd</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 20 '60</b>	
ADDRESS <b>1661-gd Hope Rd</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 115 (4)  
JSM 9/58

None

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>10 Hr 54 Min X Laurel</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		d. STREET ADDRESS <b>5th &amp; Gorman Ave., Apt. 4</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Daniel G. Notarberardino</b>		4. DATE OF DEATH Month Day Year <b>January 9 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 9, 1960</b>
9. AGE (In years lost birthday) yrs. <b>10</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>54</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Gerard Richard Notarberardino</b>		14. MOTHER'S MAIDEN NAME <b>Marcia Ann O' Donnell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>I</b>		16. SOCIAL SECURITY NO. <b>Gerard Notarberardino, Laurel, Md</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 Atelectasis</b> DUE TO <b>Chenaturity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 9, 1960</b> , to <b>JAN 9, 1960</b> , that I last saw the deceased alive on <b>JAN 9, 1960</b> , and that death occurred at <b>10:10P</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. R. Buell</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>402 Main St Laurel Md 1/10/60</b>	
PHYSICIAN'S NAME (Type) <b>Dr. John Buell</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-13-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 13 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krawt</b>			

2077202KV2

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Manner of death

8. Signature

9. Date of certificate

10. Place of certificate

11. Name of physician

12. Name of medical examiner

13. Name of registrar

14. Name of official

1039

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>7 hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>4215 72nd Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Didrik</b> Middle <b>John</b> Last <b>Osdale</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 Aug 1900</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.	IF UNDER 24 HRS. Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cartographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Norway</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hans Osdale</b>		14. MOTHER'S MAIDEN NAME <b>Malene ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Sigrid Osdale</b>		18. ADDRESS <b>4215 72nd. Ave. Landover Hills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive and arteriosclerotic cardiovascular disease.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>2,35 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4410 74 Ave Landover Hills, Md.</b> DATE SIGNED <b>1/16/60</b>			
ACTUAL SIGNATURE <b>Dr. Frederick Musser., M.D.</b>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>1/19/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1932  
CERTIFICATE OF DEATH

MAINE STATE OF MAINE - BATHING BEACH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF DECEASED: [illegible]  
SIGNATURE OF WITNESSES: [illegible]  
SIGNATURE OF MINISTER: [illegible]  
SIGNATURE OF CLERK: [illegible]

## 1115 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 1 yr., 4 months, and 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3023 14th St., N. W., Apt. #811 47x-3	
3. NAME OF DECEASED (Type or print) First Middle Last William J. Pierce		4. DATE OF DEATH Month Day Year 1 21 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/82
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Pierce		14. MOTHER'S MAIDEN NAME Anna R. Nash	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 577-20-1106	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis, right lung, with abscess, etiology 492x DUE TO undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease, bilateral obliterative pleuritis with left pleural effusion			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/3/1958, to 1/21/1960, that I last saw the deceased alive on 1/21/1960, and that death occurred at 1:40 AM, from the causes and on the date stated above. Glenn Dale Hospital DATE SIGNED 1/21/60 M.D. Glenn Dale, Md.			
ACTUAL SIGNATURE Moe Weiss		DATE SIGNED 1/21/60	
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify) 1/23/60	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges City, Md
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 2901 14th St NW		24a. REC'D BY REGISTRAR DATE JAN 25 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF BIRTH

State of New York

County of New York

City of New York

Ward of New York

Block of New York

Lot of New York

Sublot of New York



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 FilmG254 1-13-60 et

Reg. Dist. No.

01085

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>1040</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 Mount Rainier</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>3101 Perry Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Edward</b> Last <b>Poole</b>				4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-9- 1874</b>	
9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b>		IF UNDER 24 HRS. Hours <b>85</b> Min. <b>85</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Stansbury Poole</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-12-4362</b>		17. INFORMANT <b>Windsor Poole; 404 Monroe Street. Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease.</b> DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>January 5, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 8, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mountain View</b>		22d. LOCATION (City, town, or county) (State) <b>Purdom, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John L. Malowith</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 8 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Wm. L. H. H.</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01086

1041

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			e. STREET ADDRESS <b>Route 1, Box 165-A</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Albert Alkill - Powell</b>			4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-30</b>		9. AGE (In years last birthday) <b>29</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Utility Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			13. FATHER'S NAME <b>John W. Powell</b>		
14. MOTHER'S MAIDEN NAME <b>Helen Neal</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes Korean</b>		
16. SOCIAL SECURITY NO. <b>214-30-0456</b>		17. INFORMANT <b>Virginia Powell; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> <b>819X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Crushed Chest</b> (c) <b>stolting the underlying cause lost.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operator of an automobile in collision with a culvert.</b>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>1.30 P.M. 1-21-60 19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>					20f. (City or town) (County) (State) <b>Lanham Pr. Geo. Ma.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>			DATE SIGNED <b>January 21, 1960</b>		
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1.26.60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert J. McQuinn</b>		24a. REC'D BY REGISTRAR <b>JAN 25 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		24c. ADDRESS <b>1820 9th St., N.E. Washington, D.C.</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John A. Smith		AGE 45		SEX Male		RACE White		DATE OF DEATH 10-15-1910		PLACE OF DEATH Home			
RESIDENCE 1234 Main St., Baltimore, Md.		OCCUPATION Clerk		EDUCATION High School		MARRIAGE Married		SINGLE		WIDOWED			
FATHER'S NAME John A. Smith		MOTHER'S NAME Mary A. Smith		BIRTH DATE 10-15-1865		BIRTH PLACE Maryland		BIRTH TIME 10:00 AM		BIRTH WEIGHT 10 lbs.			
PREVIOUS ILLNESS None		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		SIGNATURE OF EXAMINER J. A. Smith		DATE OF EXAMINATION 10-15-1910		PLACE OF EXAMINATION Home			
TESTIMONY OF NEAREST RELATIVE I, the undersigned, being duly sworn, depose and say that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.		TESTIMONY OF MEDICAL EXAMINER I, the undersigned, being duly sworn, depose and say that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.		TESTIMONY OF JURY The jury, being duly sworn, depose and say that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.		TESTIMONY OF WITNESSES The undersigned, being duly sworn, depose and say that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.		TESTIMONY OF CLERK The undersigned, being duly sworn, depose and say that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.		TESTIMONY OF NOTARY The undersigned, being duly sworn, depose and say that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.		TESTIMONY OF OTHER OFFICIALS The undersigned, being duly sworn, depose and say that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1069 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01087

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Laurel General Hospital</b>				d. STREET ADDRESS <b>602 9th Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Lee</b> Middle <b>Powell</b> Last				4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-12-09</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government Farms</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>XXXXXXXXXX Estelle Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>219-34-7778</b>		17. INFORMANT Address <b>Thelma Powell; same address as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular renal disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				DATE SIGNED			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>January 11, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL JAN 15/60</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>BECONS CHAPEL</b>		22d. LOCATION (City, town, or county) (State) <b>Lanhamerunde Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rigley SELBY 12005 NORDEN</b>				ADDRESS <b>12005 NORDEN</b>		24c. REG'D BY REGISTRAR <b>JAN 15 1960</b>	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



ALL MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
HAWAII STATE DEPARTMENT OF HEALTH—JALIKORE, 18

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Figure 1

Indice

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2012

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## 1116 CERTIFICATE OF DEATH

01068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clinton</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jacquelyn</u> Middle <u>Cecelia</u> Last <u>Porter</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>FeM.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-12-60</u>	
9. AGE (In years last birthday) <u>6</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Prince George</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Porter</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Morton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Father</u> Address <u>Clinton 114</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> <u>692.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Cellulitis of Hand</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Skin broken at tied off extra digit</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>1 13 1960</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	
20f. (City or town) <u>Ch. 14</u> (County) <u>PG</u> (State) <u>M</u>				21. I certify that I attended the deceased from <u>1-12</u> , 19 <u>60</u> , to <u>1-18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-18</u> , 19 <u>60</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lewis Parker</u> M.D.				ADDRESS (Street, city or town, state) <u>5241 St Barnabas Rd</u> DATE SIGNED <u>1/18/60</u>			
PHYSICIAN'S NAME (Type) <u>—</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>1-21-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		22d. LOCATION (City, town, or county) <u>Clinton</u> (State) <u>md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Muriel R. Rollins</u> ADDRESS <u>4339 Hunt Pl, N.E. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>JAN 22 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077244XV6



1042

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>4 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>36 Lanham,</b> d. STREET ADDRESS <b>4823 Jefferson St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle Last <b>Proctor</b>		4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1901</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR: Months <b>5</b> Days <b>9</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myelogenous leukemia</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN 4, 1960</b> to <b>JAN 8, 1960</b> that I last saw the deceased alive on <b>JAN 8, 1960</b> and that death occurred at <b>6:15 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R.D. Bauer M.D.</b>		ADDRESS (Street, city or town, state) <b>Prince Georges General Hospital, Cheverly, Md.</b> DATE SIGNED <b>1/10/60</b>	
PHYSICIAN'S NAME (Type) <b>R.D. BAUER, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/13/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Church</b>		22d. LOCATION (City, town, or county) (State) <b>Piscataway, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Ernest James Co.</b>		ADDRESS <b>1432 York St., D.C.</b>	
24a. REC'D BY REGISTRAR <b>DATE JAN 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

STATEMENT OF DEATH

1013

DECEASED

NAME

DATE

AGE

SEX

CAUSE

PLACE

DATE

TIME

PROF

BY

DATE

PLACE



Handwritten signatures and notes at the bottom of the page.

## 1043 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>6 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
e. STREET ADDRESS <b>3727 Cottage Terrace</b>							
3. NAME OF DECEASED (Type or print) <b>Baby boy</b> First Middle Last <b>Rager</b>				4. DATE OF DEATH <b>Jan.</b> Month <b>17</b> Day <b>19</b> Year <b>60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 11, 1960</b>	
9. AGE (In years lost birthday) yrs. <b>6</b>		10. IF UNDER 1 YEAR Months <b>6</b>		11. IF UNDER 24 HRS. Hours <b>6</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Lee Roy Rager</b>				14. MOTHER'S MAIDEN NAME <b>Shirley Lobeida Eckard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mother</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive intracranial hemorrhage</b> <b>760.5</b> DUE TO <b>Interventricular septal defect</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c) <b>Prematurity</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atelectasis, fetal</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 11</b> , 19 <b>60</b> , to <b>Jan. 17</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan. 17</b> , 19 <b>60</b> , and that death occurred at <b>2:44 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Julius Kauffman</b> , M.D.				ADDRESS (Street, city or town, state) <b>5102 ANNAPOLIS RD., BLADENSBURG, Md.</b>			
PHYSICIAN'S NAME (Type) <b>JULIUS KAUFFMAN, M.D.</b>				DATE SIGNED <b>1/19/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>				22b. DATE THEREOF <b>1/18/60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W Penn, Jr.</b>				24a. REC'D BY REGISTRAR <b>FEB 1 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>Julius S. Rager</b>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1064 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01091

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b>		c. LENGTH OF STAY IN 1b <b>16 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4021 72nd Avenue</b>			e. STREET ADDRESS <b>4021 72nd Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Stephen Joseph Rakocy, Jr.</b>			4. DATE OF DEATH Month <b>January</b> Day <b>21</b> , Year <b>19 60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-20-42</b>		9. AGE (In years last birthday) <b>17</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Highschool</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Stephen J Rakocy, Jr.</b>			14. MOTHER'S MAIDEN NAME <b>Eleanor Hammond</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Stephen J. Rakocy, Sr.; same address</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>January 21, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>1/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem. Ft. Myer, Va.</b>	
22d. LOCATION (City, town, or county) <b>Washington 9, D.C.</b>		22e. (State) <b>D.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		23a. ADDRESS <b>2901 14th St. N.W.</b>		23b. REC'D BY REGISTRAR <b>JAN 28 '60</b>	
23c. (City, town, or county) <b>Washington 9, D.C.</b>		23d. (State) <b>D.C.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE  
DEPARTMENT

OFFICE OF THE  
SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.

NAVY DISCHARGE

RECEIVED  
JAN 10 1918

John T. [Name]  
[Address]

NAVY DISCHARGE  
JAN 10 1918

NAVY DISCHARGE  
JAN 10 1918

RECEIVED  
JAN 10 1918

NAVY DISCHARGE  
JAN 10 1918

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JAN 10 1918

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01092

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>			c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hosp.</b>				d. STREET ADDRESS <b>5708 40th. Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>RICHARD</b> First <b>SPURGEON</b> Middle <b>REAMY</b> Last				4. DATE OF DEATH <b>Jan.</b> Month <b>25</b> Day <b>19</b> Year <b>60</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12 Sept 1891</b>		
9. AGE (In years and birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Truck Driver</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <del>Richard</del> <b>Alexander Reamy</b>				14. MOTHER'S MAIDEN NAME <b>Maggie Reamy</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578 10 7027</b>		17. INFORMANT <b>Edna B. Reamy (Wife)</b> Address <b>Same as # 2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>January 25, 1960</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/27/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 29 '60</b>		
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



0995

## CERTIFICATE OF DEATH

01093

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u> c. LENGTH OF STAY IN 1b <u>3 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8013 14th Avenue</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 W. Hyattsville</u> d. STREET ADDRESS <u>1 8013 14th Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MILDRED</u> Middle <u>SUE</u> Last <u>REZAR</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1925</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Ross</u>	
14. MOTHER'S MAIDEN NAME <u>Burdie Lee</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>W</u>		17. INFORMANT <u>Nick Rezar, (Same as #2.)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>CORONARY OCCLUSION -</u> DUE TO (c) <u>SEVERE - CHRONIC RHEUMATIC VALVULAR HEART DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>"</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SEVERE - CHRONIC RHEUMATIC VALVULAR HEART DISEASE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>AUGUST, 1954</u> , to <u>DEC. 15, 1959</u> , that I last saw the deceased alive on <u>DEC. 15, 1959</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R. Coleman MD</u>		ADDRESS (Street, city or town, state) <u>733 SLIGO AVE</u>	
PHYSICIAN'S NAME (Type) <u>Coroner notified and approval given for Dr. J.R. Coleman to sign death certificate</u>		DATE SIGNED <u>1/13/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 16, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Monroe, Michigan</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walter</u>		24a. REC'D BY REGISTRAR <u>254 Carroll St NW</u>	
24b. REGISTRAR'S SIGNATURE <u>Jan 14 '60</u>		DATE <u>Jan 14 '60</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Date of Death: \_\_\_\_\_

7. Time of Death: \_\_\_\_\_

8. Cause of Death: \_\_\_\_\_

9. Place of Death: \_\_\_\_\_

10. Signature of Physician: \_\_\_\_\_

11. Signature of Registrar: \_\_\_\_\_

12. Date of Registration: \_\_\_\_\_



1117

## CERTIFICATE OF DEATH

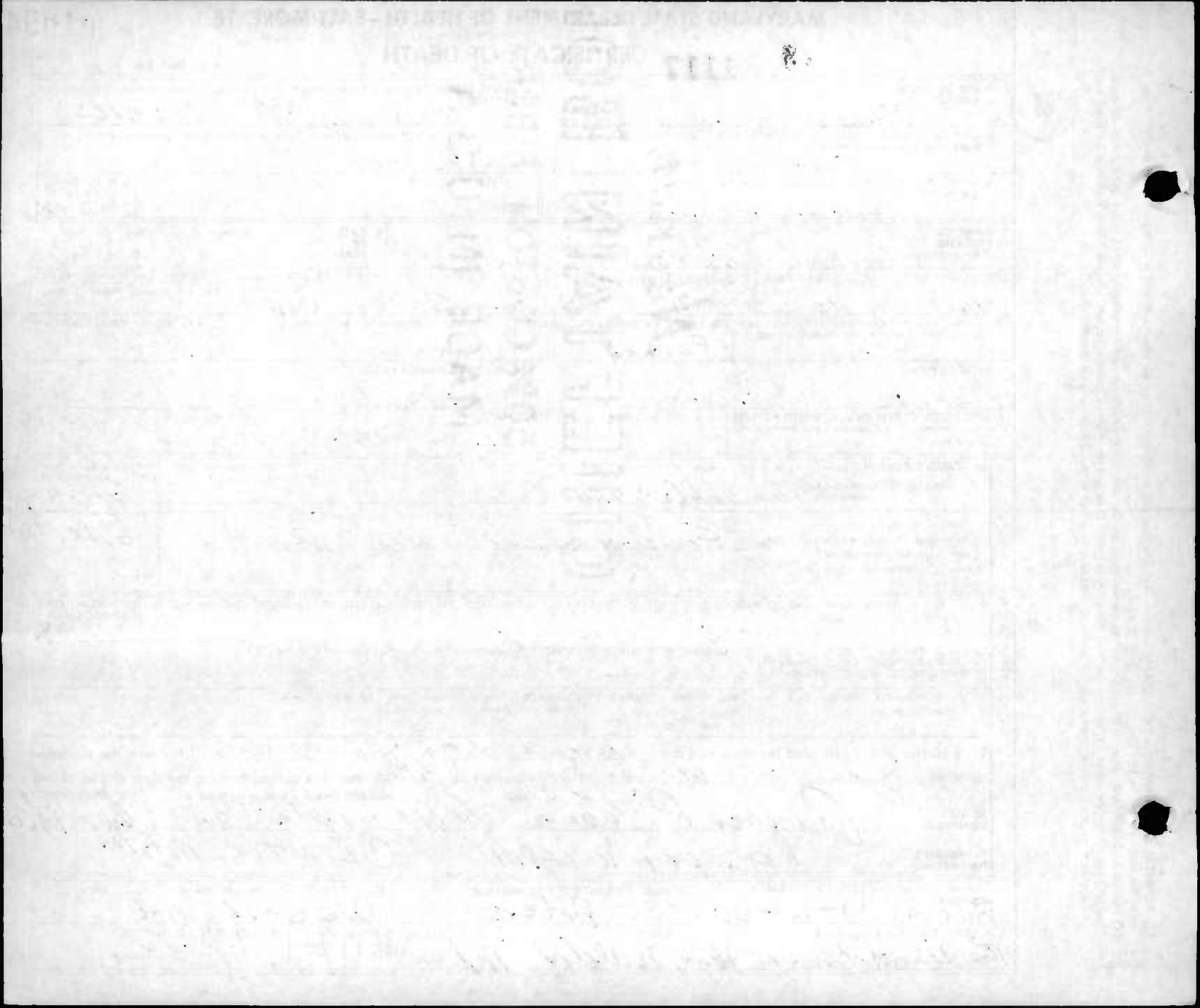
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u> <u>08X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOUTHERN MARYLAND Hosp</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William DANIEL RICHARDSON</u>				4. DATE OF DEATH Month Day Year <u>1 3 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 21-1890</u>	9. AGE (In years last birthday) yrs. <u>79 1/2</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LAWRENCE RICHARDSON</u>				14. MOTHER'S MAIDEN NAME <u>BENNIE SWANN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		INFORMANT <u>ELIZABETH MARIE PROCTOR</u>		Address <u>(Waldorf, Md)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>1977X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>CARCINOMA OF THE PROSTATE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY CONGESTION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>59</u> , to <u>Jan 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 3</u> , 19 <u>60</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>So Md Hospital Center Clinton, Md</u> DATE SIGNED <u>Jan 11/60</u> ACTUAL SIGNATURE <u>Alfred R. Lapin, M.D.</u> PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN</u> <u>CLINTON, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Shunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0996

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges'</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5005 55TH AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs MARGARET CAROLYN ROBERTSON</u>		4. DATE OF DEATH <u>JAN. 6 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 21, 1916</u>
9. AGE (In years lost birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANK</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES CLIFTON FREEER</u>		14. MOTHER'S MAIDEN NAME <u>Mrs MARY ANN WALKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416 X VENTRICULAR FIBRILLATION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO (c) <u>6 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUL 4</u> , 19 <u>55</u> , to <u>1/6/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/6</u> , 19 <u>60</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>NORMAN DONAT COMEAU</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 PENNY ST MT RAINIER MD</u> DATE SIGNED <u>1/6/60</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMEAU</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/9/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 8 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OK by Dr John Maloney

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH



1

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF WITNESS: [illegible]  
OFFICIAL USE: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12, 13, 14 Film G256 2-11-60 et

1044

## CERTIFICATE OF DEATH

Reg. Dist. No.

01096

1. PLACE OF DEATH o. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN <b>Prince Georges</b> RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>6 hr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julius</b> Middle <b>James</b> Last <b>Robinson</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1896</b>
9. AGE (In years lost birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George Robinson</b>	
14. MOTHER'S MAIDEN NAME <b>Carrie Robinson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>army 1917-1919</b>	
16. SOCIAL SECURITY NO. <b>1917-1919</b>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pul. empy &amp; edema</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gen. Arterio sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 12, 1960</b> , to <b>Jan. 12, 1960</b> , that I last saw the deceased alive on <b>Jan. 12, 1960</b> , and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Prince George's General Hospital 1-13-60</b>			
ACTUAL SIGNATURE <b>R.D. BAKER</b>		PHYSICIAN'S NAME (Type) <b>R.D. BAKER, M.D.</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 18, 60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery, Va.</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walt H. Williams</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 3 '60</b>	
ADDRESS <b>4445 Reed</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**1079 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01097

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>65</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6407 45th Place</b>			d. STREET ADDRESS <b>6407 45th Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Leo Eva Robison</b>			4. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>19 60</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 2, 1889</b>		9. AGE (In years last birthday) <b>70</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gov't clerk</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	
13. FATHER'S NAME <b>Don Edward Rachford</b>			14. MOTHER'S MAIDEN NAME <b>Mary Comstock</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Philip C Rachford; 409 Main Street, Grosspoint Farms, Michigan</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Acute pneumonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiovascular renal disease</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John T. Maloney</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>January 23, 1960</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>1/27/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>	
				22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co.</b>			24a. REC'D BY REGISTRAR DATE <b>JAN 26 '60</b>		
ADDRESS <b>2901 14th St. N.W. Wash, D.C.</b>			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.



107  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. MANNER OF DEATH: [illegible]  
9. SIGNATURE OF EXAMINER: [illegible]  
10. DATE: [illegible]

## 1001 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>				c. LENGTH OF STAY IN 1b <b>84 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7100 Fresno St</b>				d. STREET ADDRESS <b>7100 Fresno St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Mary M Sass</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>Femal</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1875</b>	9. AGE (In years less birthday) yrs. <b>84</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
13. FATHER'S NAME <b>Fredrick Winters</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Son</b> <b>Jone E. Hamlen</b>		Address <b>7100, Fresno. St</b> <b>Seat Pleasant, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>1-13</b> , 19 <b>60</b> , to <b>1-27</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-25</b> , 19 <b>60</b> , and that death occurred at <b>9 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MD</b> DATE SIGNED <b>1/27/60</b> ACTUAL SIGNATURE <b>Max M. Herzberg</b> M.D. <b>7016-GREIG ST, SEAT-PLEASANT</b> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Landon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers CO.</b>				ADDRESS <b>Riverdale, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 29 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 ~~X~~ 01099  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**1045 CERTIFICATE OF DEATH**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges County</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly, Md.</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>44 Cheverly Manor, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Helen</u> Middle <u>Agnes</u> Last <u>Schultz</u>				<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>25</u> Year <u>19 60</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 4, 1901</u>			
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					
13. FATHER'S NAME <u>John Long</u>				14. MOTHER'S MAIDEN NAME <u>Agnes ?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT <u>Wm F. Schults</u> Address <u>Same as No 2</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> DUE TO <u>331x</u> (b) <u>Cerebrovascular Arteriosclerosis</u> DUE TO <u>Arteriosclerosis Generalized</u> (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> to <u>Jan 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 25</u> , 19 <u>60</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>William D. Rosson M.D.</u>				ADDRESS (Street, city or town, state) <u>5304 Annapolis Road</u>					
PHYSICIAN'S NAME (Type) <u>William D. Rosson M D</u>				DATE SIGNED <u>1/25/60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>				24c. REGISTRAR'S SIGNATURE <u>  </u>					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0100

# INSTRUCTIONS

1. The purpose of this document is to provide instructions for the use of the system. It is intended for use by all personnel who are responsible for the operation of the system.

2. The system is designed to provide a secure and reliable means of communication. It is capable of handling a large volume of traffic and is able to operate in a variety of environments.

3. The system is operated by a central control unit. This unit is responsible for the distribution of messages and the monitoring of the system's performance.

4. The system is capable of operating in a variety of modes. These modes include normal operation, test operation, and maintenance operation.

5. The system is capable of operating in a variety of environments. These environments include indoor and outdoor operation, and operation in a variety of climates.

6. The system is capable of operating in a variety of configurations. These configurations include single and multiple channel operation, and operation in a variety of network topologies.

7. The system is capable of operating in a variety of modes. These modes include normal operation, test operation, and maintenance operation.

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10. The system is capable of operating in a variety of modes. These modes include normal operation, test operation, and maintenance operation.

Information for the user  
The user should refer to the  
manual for more information  
on the use of the system.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1045

01100

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp</u>				d. STREET ADDRESS <u>Box 59 - Rt. 1 -</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gregory</u> Middle <u>Scrivner</u> Last <u>Scrivner</u>				4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-59</u>		9. AGE (In years last birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Scrivner</u>				14. MOTHER'S MAIDEN NAME <u>Louise Pinkney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother - Same address</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-13-60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) <u>Benning rd. S. E.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Washington</u> ADDRESS <u>467 N. St. 740</u>				24a. REC'D BY REGISTRAR <u>JAN 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01101

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <span style="float:right">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float:right">b. COUNTY <b>Prince George's</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodmore</b>			c. LENGTH OF STAY IN lb <b>9 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodmore</b> <span style="float:right">05</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Woodmore Road</b>				d. STREET ADDRESS <b>Woodmore Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ARTHUR</b> <span style="float:right">First</span> <b>LEON</b> <span style="float:right">Middle</span> <b>SELLMAN</b> <span style="float:right">Last</span>				<b>4. DATE OF DEATH</b> <b>Jan.</b> <span style="float:right">Month</span> <b>1</b> <span style="float:right">Day</span> <b>1960</b> <span style="float:right">Year</span>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Colored</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>March 2, 1926</b>	
<b>9. AGE</b> (In years last birthday) <b>33</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>
<b>13. FATHER'S NAME</b> <b>Arthur Charles Sellman</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Lilly Jones</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>?</b>		<b>17. INFORMANT</b> <span style="float:right">Address</span> <b>Arthur C. Sellman Mitchellville, Md. (Father)</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemopericardium</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rupture of right auricular appendage</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)
<b>21. I certify</b> that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> <span style="float:right">M.D.</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME</b> (Type) <b>JOHN T. MALONEY, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial 1-6-1960</b>			<b>22b. DATE THEREOF</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Union Chapel</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>MD. Kendrae Md.</b>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>William Reese</i>				<b>ADDRESS</b> <b>Arden Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>JAN 13 '60</b>	
				<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Evans</i>			

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of Medical Examiner	
9. Signature of Coroner		10. Signature of Physician		11. Signature of Juror		12. Signature of Jury	
13. Signature of Witness		14. Signature of Juror		15. Signature of Jury		16. Signature of Juror	
17. Signature of Juror		18. Signature of Jury		19. Signature of Juror		20. Signature of Jury	
21. Signature of Juror		22. Signature of Jury		23. Signature of Juror		24. Signature of Jury	
25. Signature of Juror		26. Signature of Jury		27. Signature of Juror		28. Signature of Jury	
29. Signature of Juror		30. Signature of Jury		31. Signature of Juror		32. Signature of Jury	
33. Signature of Juror		34. Signature of Jury		35. Signature of Juror		36. Signature of Jury	
37. Signature of Juror		38. Signature of Jury		39. Signature of Juror		40. Signature of Jury	
41. Signature of Juror		42. Signature of Jury		43. Signature of Juror		44. Signature of Jury	
45. Signature of Juror		46. Signature of Jury		47. Signature of Juror		48. Signature of Jury	
49. Signature of Juror		50. Signature of Jury		51. Signature of Juror		52. Signature of Jury	
53. Signature of Juror		54. Signature of Jury		55. Signature of Juror		56. Signature of Jury	
57. Signature of Juror		58. Signature of Jury		59. Signature of Juror		60. Signature of Jury	
61. Signature of Juror		62. Signature of Jury		63. Signature of Juror		64. Signature of Jury	
65. Signature of Juror		66. Signature of Jury		67. Signature of Juror		68. Signature of Jury	
69. Signature of Juror		70. Signature of Jury		71. Signature of Juror		72. Signature of Jury	
73. Signature of Juror		74. Signature of Jury		75. Signature of Juror		76. Signature of Jury	
77. Signature of Juror		78. Signature of Jury		79. Signature of Juror		80. Signature of Jury	
81. Signature of Juror		82. Signature of Jury		83. Signature of Juror		84. Signature of Jury	
85. Signature of Juror		86. Signature of Jury		87. Signature of Juror		88. Signature of Jury	
89. Signature of Juror		90. Signature of Jury		91. Signature of Juror		92. Signature of Jury	
93. Signature of Juror		94. Signature of Jury		95. Signature of Juror		96. Signature of Jury	
97. Signature of Juror		98. Signature of Jury		99. Signature of Juror		100. Signature of Jury	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01102

1047

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b> c. LENGTH OF STAY IN lb <b>3 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W. Hyattsville, 51</b> d. STREET ADDRESS <b>2631 Nicholson St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>C</b> Last <b>Shirkey</b>			4. DATE OF DEATH Month <b>January</b> Day <b>16</b> Year <b>19 60</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Jan 13, 1905</b>		9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Security Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nat'l. Aet. Agency</b>		11. BIRTHPLACE (State or foreign country) <b>Clintonville, W. Va</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>George C. Shirkey</b>		14. MOTHER'S MAIDEN NAME <b>Julia Lee Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		INFORMANT <b>Lillian Shirkey</b> Address <b>Same as 2A.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 year</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1019 University Boulevard, East</b>	
20f. (City or town) <b>Silver Spring, Maryland</b>		(County) <b>Montgomery</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>January 9, 1960</b> , to <b>January 16, 1960</b> , that I last saw the deceased alive on <b>January 16, 1960</b> , and that death occurred at <b>8:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1019 University Boulevard, East</b> DATE SIGNED <b>1/17/60</b>					
ACTUAL SIGNATURE <b>Boris Rabkin</b>		PHYSICIAN'S NAME (Type) <b>BORIS RABKIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/21/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rosewood</b>	
22d. LOCATION (City, town, or county) <b>East Rainelle, W. Va.</b>		(State) <b>W. Va.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co., Riverdale, Md.</b>		ADDRESS <b>Riverdale, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 21 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knap</b>					



1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

1113

2150



01103

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanier (Rural)</u> <u>13X-2</u>		d. STREET ADDRESS <u>Route #1 Box 217</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Delmar Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sussie</u> First <u>Sissons</u> Middle <u></u> Last <u></u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Crown home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore County Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Hopkins</u>		14. MOTHER'S MAIDEN NAME <u>Ellen C. Hannan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Hwa Sissons Lanier</u>		Address <u>Delmar</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 9</u> , 19 <u>59</u> , to <u>Jan 7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 7</u> , 19 <u>60</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert S. McCeney</u> M.D.		ADDRESS (Street, city or town, state) <u>402 MAIN ST. LAUREL, MD.</u>	
DATE SIGNED <u>JAN 11 '60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-11-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Larkwood Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Hartford Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 11 '60</u>		24b. REGISTRAR'S SIGNATURE	

**HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. This certificate may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1913 CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
JAMES H. HARRIS		Male		45		Jan 15, 1868		Maryland		Farmer	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF DECEASED	
Home		Heart Disease		Natural		Jan 25, 1913		10:00 AM		James H. Harris	
13. NAME OF PHYSICIAN		14. NAME OF FUNERAL HOME		15. NAME OF BURIAL PLACE		16. NAME OF MINISTER		17. NAME OF WITNESSES		18. NAME OF REGISTRAR	
Dr. J. H. Smith		J. H. Smith & Co.		St. John's Church		Rev. J. H. Smith		J. H. Smith & Co.		J. H. Smith	
19. NAME OF REGISTRAR		20. NAME OF REGISTRAR		21. NAME OF REGISTRAR		22. NAME OF REGISTRAR		23. NAME OF REGISTRAR		24. NAME OF REGISTRAR	
J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. PLACE OF DEATH  
8. CAUSE OF DEATH  
9. MANNER OF DEATH  
10. DATE OF DEATH  
11. TIME OF DEATH  
12. SIGNATURE OF DECEASED  
13. NAME OF PHYSICIAN  
14. NAME OF FUNERAL HOME  
15. NAME OF BURIAL PLACE  
16. NAME OF MINISTER  
17. NAME OF WITNESSES  
18. NAME OF REGISTRAR  
19. NAME OF REGISTRAR  
20. NAME OF REGISTRAR  
21. NAME OF REGISTRAR  
22. NAME OF REGISTRAR  
23. NAME OF REGISTRAR  
24. NAME OF REGISTRAR

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1048

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01104

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vienna</b> <b>83X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>Rt. # 4 Box 489</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>CHARLES COBB SMITH</b> First Middle Last				4. DATE OF DEATH Month <b>Jan.</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 14, 1898</b>		9. AGE (In years and birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elect. Engr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>P.E.P.Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles H. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Harriet m. Cobb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 577 05 0644</b>		17. INFORMANT Address <b>Wm. W. Smith (Son) Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Crushed chest</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Operator of an automobile in collision with another automobile.</b>					
20c. TIME OF INJURY Month, Day, Year <b>6:30 a.m. January 1, 1960</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Muirkirk Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>January 1, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-4-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Falls Church Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DM Pickenberger</b>				ADDRESS <b>171 Maple Ave. Va.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 5 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hester</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01105

1119

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lakeland</b>		c. LENGTH OF STAY IN 1b <b>6 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4811 Navahoe Street</b>		d. STREET ADDRESS <b>4811 Navahoe Street</b>	
3. NAME OF DECEASED (Type or print) <b>Natalie Roxanne Smith</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-19-53</b>
9. AGE (In years last birthday) <b>6 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b> Hours <b>53</b> Min.	11. IF UNDER 24 HRS. Months <b>6</b> Days <b>19</b> Hours <b>53</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Smith</b>		14. MOTHER'S MAIDEN NAME <b>Willie Mae Potts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>3 2.</b>	
17. INFORMANT <b>Betty Varnell Turner; same address as 3 2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1st., 2nd., and 3rd degree burns of body.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Conflagration in home</b>	
20c. TIME OF INJURY Month, Day, Year <b>12-40-19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Lakeland Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>January 24, 1960</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/26/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		22d. LOCATION (City, town, or county) (State) <b>Muirkirk, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Ernest Jarvis Co., Inc.</b>		24a. REC'D BY REGISTRAR <b>26 '60</b>	
ADDRESS <b>1432 You St., N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kneass</b>	



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Race		5. Date of Death		6. Place of Death	
John Doe		Male		45		White		Jan 15, 1950		Home	
7. Cause of Death		8. Manner of Death		9. Signature of Examiner		10. Signature of Coroner		11. Signature of Physician		12. Signature of Medical Examiner	
Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]	
13. Date of Burial		14. Place of Burial		15. Signature of Burial Officer		16. Signature of Minister		17. Signature of Undertaker		18. Signature of Medical Examiner	
Jan 20, 1950		Cemetery		[Signature]		[Signature]		[Signature]		[Signature]	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE HEALTH DEPARTMENT, BALTIMORE, MARYLAND.



## CERTIFICATE OF DEATH

01186

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vista (Rural)</u>		c. LENGTH OF STAY IN 1b <u>9 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt # 50</u>		d. STREET ADDRESS <u>Rt # 50</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Willie Bernard Smith</u>		4. DATE OF DEATH Month Day Year <u>Jan. 14, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17, 1888</u>
9. AGE (In years last birthday) <u>71 1/2</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NCHA</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Mary E Smith</u> Address <u>Vista, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1953</u> , to <u>Jan 14, 1960</u> , that I last saw the deceased alive on <u>Jan 13, 1960</u> , and that death occurred at <u>10:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry A. Wilson Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>7005 Volta St Lanham, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Henry A. Wilson Jr.</u>		DATE SIGNED <u>Jan 18 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nat. Harmony</u>	22d. LOCATION (City, town, or county) (State) <u>Shorth Rd. Ept Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u> ADDRESS <u>4925 Gleane Ave</u>		24a. REC'D BY REGISTRAR <u>JAN 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 1049 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby First Boy Middle Last Snyder		4. DATE OF DEATH Jan Month Day 12 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-60
9. AGE (In years lost birthday) yrs.		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Snyder		14. MOTHER'S MAIDEN NAME Bernice Gesek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Hosp. Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.0 DUE TO <i>acute cranial meningitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>breast carcinoma</i> DUE TO (c) <i>breast carcinoma</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/12, 1960, to 1/12, 1960, that I last saw the deceased alive on 1/12, 1960, and that death occurred at 9:05 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2015 R St. DATE SIGNED			
ACTUAL SIGNATURE <i>J. Francis Warren</i> M.D.		2015 R St.	
PHYSICIAN'S NAME (Type) Dr. J. Francis Warren		Washington D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/1960	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE JAN 14 '60	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4

2077272XV6

MAINE AND STATE OF MAINE IN HEALTH DEPARTMENT  
1012  
CERTIFICATE OF DEATH  
BY MEDICAL EXAMINER  
Name of Deceased  
Age  
Sex  
Date of Death  
Place of Death  
Cause of Death  
Disease or Injury  
Signature of Medical Examiner  
Signature of Registrar  
Date of Registration

## 1050 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>6 da.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Patricia B. Swann</b>			4. DATE OF DEATH Month Day Year <b>Jan. 18 1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>C Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-20-59</b>		9. AGE (In years lost birthday) yrs. <b>8</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Bernard Swann</b>			14. MOTHER'S MAIDEN NAME <b>Patricia Proctor</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. INFORMANT Address <b>None Bernard Swann Rt. 3 Box 580 A. Clinton Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>344X</b> DUE TO <b>Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Hydrocephalus</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>Jan. 12 1960</b> to <b>Jan. 18, 1960</b> , that I last saw the deceased alive on <b>Jan. 18, 1960</b> , and that death occurred at <b>10:50 AM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Albert J. Modlin</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>388 Montrose Ave., Laurel, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Albert J. Modlin . 388 Montrose Ave., Laurel Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 21 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>	
22d. LOCATION (City, town, or county) <b>Clinton, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Funeral Home, Haldorf, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JAN 22 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knap</b>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2677181XV4

B.

Maryland

Inspector

Swann

Bernard Swann K3 B2284 10





CERTIFICATE OF DEATH

File Date

1. NAME OF DECEASED [Name]		2. SEX [Male/Female]		3. AGE [Age]		4. DATE OF BIRTH [Date]		5. PLACE OF BIRTH [Place]	
6. OCCUPATION [Occupation]		7. MARITAL STATUS [Single/Married/Divorced/Widowed]		8. EDUCATION [Education]		9. RELIGION [Religion]		10. RACE [Race]	
11. CAUSE OF DEATH [Cause]		12. MANNER OF DEATH [Manner]		13. DATE OF DEATH [Date]		14. TIME OF DEATH [Time]		15. PLACE OF DEATH [Place]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF PHYSICIAN [Signature]		19. SIGNATURE OF CORONER [Signature]		20. SIGNATURE OF JURY [Signature]	
21. SIGNATURE OF REGISTRAR [Signature]		22. SIGNATURE OF CLERK [Signature]		23. SIGNATURE OF CHIEF OF BUREAU [Signature]		24. SIGNATURE OF ASSISTANT CHIEF OF BUREAU [Signature]		25. SIGNATURE OF DEPUTY CHIEF OF BUREAU [Signature]	

1051  
CERTIFICATE OF DEATH

Reg. Dist. No.

01110

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>20 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Thies</b> Last <b>Thies</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>31</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 12, 1878</b>	
9. AGE (In years lost birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min.		IF UNDER 24 HRS. Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>			
11. BIRTHPLACE (State or foreign country) <b>Transylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>578 34 3936</b>			
17. INFORMANT <b>Katharina Thies</b>				Address <b>College Park, Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Coronary thrombosis</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 Cerebral hemorrhage</b> (b) <b>Pyelonephritis, cystitis &amp; prostatitis</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 10, 1960</b> to <b>Jan. 31, 1960</b> , that I last saw the deceased alive on <b>Jan. 31, 1960</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>4713 Berwyn Rd College Park, Md</b>							
DATE SIGNED <b>Feb 4 '60</b>							
ACTUAL SIGNATURE <b>W.L. ETIENNE</b>							
PHYSICIAN'S NAME (Type) <b>W.L. ETIENNE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>2/3/60</b>							
22c. NAME OF CEMETERY OR CREMATOR <b>Trinity Lutheran</b>							
22d. LOCATION (City, town, or county) (State) <b>Bowie, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>							
ADDRESS <b>F. Gasch's Sons Hyattsville, Md.</b>							
24a. REC'D BY REGISTRAR <b>FEB 4 '60</b>							
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>							

TO HOSPITAL. THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF MARRIAGE

State of New York

County of ...

City of ...

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1052 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01111

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>Rt. 1, Box 121</b>								
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Francis</b> Middle <b>William</b> Last <b>Thomas</b>				<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>10,</b> Year <b>19 60</b>								
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Col.</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>								
<b>8. DATE OF BIRTH</b> <b>11-19-20</b>		<b>9. AGE</b> (In years last birthday) <b>39</b> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Hours</td> </tr> <tr> <td>Days</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Hours	Days	Min.			
IF UNDER 1 YEAR	IF UNDER 24 HRS.											
Months	Hours											
Days	Min.											
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>								
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>												
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Rosie Brook</b>								
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>579-12-98</b>		<b>17. INFORMANT</b> <b>Agnes Thomas; same address as # 2.</b>								
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Hemorrhage and shock</b>  <b>981X</b>  <b>DUE TO</b> </td> <td rowspan="3"> <b>INTERVAL BETWEEN ONSET AND DEATH</b> </td> </tr> <tr> <td colspan="2"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b) Gunshot wound of chest and abdomen</b>  <b>DUE TO</b> </td> </tr> <tr> <td colspan="2"> <b>(c)</b> </td> </tr> </table>						<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Hemorrhage and shock</b> <b>981X</b> <b>DUE TO</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b) Gunshot wound of chest and abdomen</b> <b>DUE TO</b>		<b>(c)</b>	
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Hemorrhage and shock</b> <b>981X</b> <b>DUE TO</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>										
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b) Gunshot wound of chest and abdomen</b> <b>DUE TO</b>												
<b>(c)</b>												
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>												
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Shot by a gun held in the hands of another person.</b>										
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>3:15</b> <b>1-10-60</b> <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Street</b>								
<b>20f. (City or town)</b> <b>Vista-</b>		<b>(County)</b> <b>Pr. Geo.</b>		<b>(State)</b> <b>Md.</b>								
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Noturol causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
<b>ACTUAL SIGNATURE</b> <i>John T. McJoney</i>		<b>EXAMINER'S NAME (Type)</b> <b>John T. McJoney, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>								
<b>DATE SIGNED</b> <b>January 10, 1959</b>												
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>1-13-60</b>		<b>22b. DATE THEREOF</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Fam. Chr. Cemetery</b>								
<b>22d. LOCATION (City, town, or county)</b> <b>Woodmoor, Md.</b>		<b>(State)</b>										
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Henry Washington</i>		<b>ADDRESS</b> <b>4925 Adams Ave.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>JAN 14 '60</b>								
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Evans</i>												

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay in execution, the certificate should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		CITY OF BIRTH [REDACTED]	
OCCUPATION [REDACTED]		EDUCATION [REDACTED]	
MARRIAGE [REDACTED]		RELIGION [REDACTED]	
PREVIOUS ILLNESS [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		SIGNATURE OF EXAMINER [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		CITY OF DEATH [REDACTED]	
STATE OF DEATH [REDACTED]		COUNTY OF DEATH [REDACTED]	
FAMILY HISTORY [REDACTED]		SOCIAL HISTORY [REDACTED]	
PHYSICAL HISTORY [REDACTED]		MENTAL HISTORY [REDACTED]	
LABORATORY TESTS [REDACTED]		X-RAY [REDACTED]	
PATHOLOGICAL FINDINGS [REDACTED]		MICROSCOPIC FINDINGS [REDACTED]	
TOXICOLOGICAL FINDINGS [REDACTED]		IMMUNOLOGICAL FINDINGS [REDACTED]	
OTHER FINDINGS [REDACTED]		SIGNATURE OF PATHOLOGIST [REDACTED]	
DATE OF REPORT [REDACTED]		TIME OF REPORT [REDACTED]	
PLACE OF REPORT [REDACTED]		CITY OF REPORT [REDACTED]	
STATE OF REPORT [REDACTED]		COUNTY OF REPORT [REDACTED]	



## 1070 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		c. LENGTH OF STAY IN <i>4 mo. 27 da</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Laurel Sanitarium</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Helen</i> Middle <i>P.</i> Last <i>Thompson</i>		4. DATE OF DEATH Month <i>1</i> Day <i>12</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 3. 1879</i>
9. AGE (In years last birthday) <i>80</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse &amp; housewife</i>		12. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Thomas Parsons</i>		14. MOTHER'S MAIDEN NAME <i>Juliet Reeder</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> 446 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Nephrosclerosis</i> DUE TO (c) <i>General Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3-4 weeks</i> <i>indeterminate</i> <i>Many years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-16</i> , 19 <i>60</i> to <i>8-12</i> , 19 <i>60</i> that I last saw the deceased alive on <i>8-11</i> , 19 <i>60</i> , and that death occurred at <i>8:25 P.</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Jesse C. Coggins</i>		ADDRESS (Street, city or town, state) <i>Laurel Sanitarium</i>	
PHYSICIAN'S NAME (Type) <i>Jesse C. Coggins-M.D.</i>		DATE <i>8-16-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>JAN. 15, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Woodlawn Balto. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins &amp; Sons Co.</i>		ADDRESS <i>4905 York Road</i>	
24a. REC'D BY REGISTRAR <i>JAN 14 1960</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Fennell</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE OF THE COMPTROLLER

REPORT OF THE COMPTROLLER  
FOR THE YEAR 1900

ALBANY, N. Y., JANUARY 1, 1901

THE COMPTROLLER HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF THE REPORT OF THE COMPTROLLER FOR THE YEAR 1900, AND TO STATE THAT THE SAME HAS BEEN FILED IN THE OFFICE OF THE COMPTROLLER.

IN WITNESS WHEREOF, I HAVE HEREUNTO SET MY HAND AND SEAL, AT ALBANY, N. Y., THIS 1ST DAY OF JANUARY, 1901.

JOHN W. ALLEN, COMPTROLLER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01113

1121

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Allentown</b>	c. LENGTH OF STAY IN 1b <b>12</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Allentown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6711 Allentown Road</b>		d. STREET ADDRESS <b>6711 Allentown Road</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>RICHARD</b> Last <b>THORNE</b>		4. DATE OF DEATH Month <b>January</b> Day <b>15</b> , Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1902</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>57</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Repair Ret. Service Station</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Millard Thorne</b>		14. MOTHER'S MAIDEN NAME <b>Edith Buck</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-32-4610</b>	
17. INFORMANT <b>Mrs. Dorothy A. Thorne, Same as # 2. Wife.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardio Vascular Renal Disease</b> (c) <b>DUE TO</b> (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M. D.</b>		DATE SIGNED <b>January 15, 1960.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 18-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Washington National Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Brothers</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

500

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

## Reg. Dist. No.

1122

MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/5B

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1053 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G255 2-1-60 et

01115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>Dead on arrival</b> X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>Unknown</b>	
3. NAME OF DECEASED (Type or print) First <b>Parnell</b> Middle <b>Wallace</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/12</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>17</b>	11. IF UNDER 24 HRS. Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Filling Station</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year and dates of service) <b>Yes</b> <b>W.W.II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Police Records, Prince Geo. Cty. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>490 X</b> <b>Acute congestive heart failure</b> DUE TO <b>Lobar pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DATE SIGNED <b>1/20/58 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 26, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO., Riverdale, Md.</b>		24. REC'D BY REGISTRAR <b>Jan 27 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME  
BM 2/57

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE		ARMY SERVICE		MARINE SERVICE		COAST GUARD SERVICE		OTHER SERVICE		REMARKS	
Carpenter		High School		Married		Roman Catholic		None		None		None		None		None		None		None		None	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
Heart Failure		Natural		10 days		10/15/1918		10:30 AM		Home		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER		PREVIOUS OTHER		PREVIOUS OTHER		PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None		None	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTY OF EXAMINATION		STATE OF EXAMINATION		CITY OF EXAMINATION		COUNTY OF EXAMINATION		STATE OF EXAMINATION		CITY OF EXAMINATION		COUNTY OF EXAMINATION	
J. H. HARRIS		Physician		10/15/1918		Home		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

TO THE PUBLIC: This is to certify that the above is a true and correct copy of the original record as kept in the files of the State Department of Health, Baltimore, Maryland, and that the same has been compared with the original and found to be correct.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1054 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pg-Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>P.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>				d. STREET ADDRESS <u>4623 - Burlington Rd</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wilo Thomas Walter</u>		4. DATE OF DEATH <u>Jan 10 1960</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct-16, 1885</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Walter</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>Navy</u>		17. INFORMANT <u>Wilo Walter - 4621 Burlington Road, Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>492X</u> DUE TO <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute pneumonia</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Jan-11-1960</u>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 13, 1960</u>		22c. NAME OF CEMETERY OR OBTUQUARY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch &amp; Sons</u>				ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>Jan 14 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thana</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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100 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME OF DECEASED: *John T. Brown*  
 SEX: *Male*  
 AGE: *45*  
 DATE OF DEATH: *11-11-1911*  
 PLACE OF DEATH: *Home*  
 OCCUPATION: *Teacher*  
 CAUSE OF DEATH: *Heart failure*  
 DISEASE OR INJURY: *Myocarditis*  
 PERIOD OF ILLNESS: *2 weeks*  
 PLACE OF ILLNESS: *Home*  
 NAME OF PHYSICIAN: *Dr. J. H. Smith*  
 ADDRESS: *123 Main St.*  
 CITY: *Baltimore*  
 COUNTY: *Baltimore*  
 STATE: *Maryland*  
 SIGNATURE OF EXAMINER: *John T. Brown*  
 DATE: *11-11-1911*

## 1055 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beaver Heights</b> d. STREET ADDRESS <b>1903 Kennilworth Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Wesley</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 Jan 1960</b>
9. AGE (In years last birthday) <b>2</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Wesley</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Howard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 Atelectasis</b> DUE TO <b>Postmaturity</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Postmaturity</b> DUE TO (c) <b>Postmaturity</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 15, 1960</b> to <b>Jan 17, 1960</b> , that I last saw the deceased alive on <b>Jan 17, 1960</b> , and that death occurred at <b>6:55 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John W. Perkins</b>		ADDRESS (Street, city or town, state) <b>5301 Hamilton St. Hyattsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. John W. Perkins, M.D.</b>		DATE SIGNED <b>1/17/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	22b. DATE THEREOF <b>1/21/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator.</b>		24a. REC'D BY REGISTRAR <b>JAN 22 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

2077367XV4

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Burial Officer

Signature of Minister

Signature of Undertaker

Signature of Witness

Signature of Burial Officer

Signature of Minister

Signature of Undertaker

Signature of Witness

Signature of Burial Officer



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 18 Film 257 3-1-60 ans									
1056 CERTIFICATE OF DEATH									
Reg. Dist. No. 02425									
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					c. LENGTH OF STAY IN 1b <b>7 Days</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>					d. STREET ADDRESS <b>Box 26</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Baby Boy Titus Andrew West</b>					4. DATE OF DEATH <b>Jan 29 19 60</b>				
5. SEX <b>Male</b>					6. COLOR OR RACE <b>Colored</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>Jan. 22, 1960</b>				
9. AGE (In years lost birthday) yrs. <b>7</b>					10. IF UNDER 1 YEAR Months <b>7</b>				
11. IF UNDER 24 HRS. Hours <b>7</b> Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland U.S.A.</b>				
11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <b>Thomas Arthur West</b>					14. MOTHER'S MAIDEN NAME <b>Pauline Catherine Savoy</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.									
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>Jan. 22</b> , 19 <b>60</b> , to <b>Jan 29</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Jan 29</b> , 19 <b>60</b> , and that death occurred at <b>8 A. M.</b> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>5301 Hawthorne St., Hyattsville, Md.</b> DATE SIGNED <b>1/29/60</b>									
ACTUAL SIGNATURE <b>Dr. John W. Perkins, M.D.</b>									
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>									
22b. DATE THEREOF <b>2/9/60</b>									
22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>									
22d. LOCATION (City, town, or county) (State)									
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator.</b>									
24a. REC'D BY REGISTRAR <b>FEB 11 '60</b>									
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Smith</b>									

2077235XU3

M

1027 - CERTIFICATE OF DEATH

MINNESOTA

Given name: [illegible]  
Surname: [illegible]  
Date of birth: [illegible]  
Place of birth: [illegible]  
Date of death: [illegible]  
Place of death: [illegible]

Issued at [illegible]

Witnessed by [illegible]

Dr. John A. [illegible]

Witnessed by [illegible]

Dr. [illegible]

[illegible]

## 1057 CERTIFICATE OF DEATH

Reg. Dist. No.

01118

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>19 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>9137 Baltimore Ave.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>J.</b> Last <b>Whitehead</b>			4. DATE OF DEATH Month <b>1</b> Day <b>27</b> Year <b>19 60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-13-79</b>		9. AGE (In years lost birthday) <b>80</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>carpenter</b>	11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Wm H Whitehead</b>			14. MOTHER'S MAIDEN NAME <b>Sarah C Mc Donald</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		INFORMANT Address <b>Florence Satterlee College Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1-9-60</b> , 19 <b>60</b> , to <b>JAN 27, 1960</b> , that I last saw the deceased alive on <b>JAN 27, 1960</b> , and that death occurred at <b>4:35 PM</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Benjamin S. Miller</b>		M.D. <b>3824 34th St.</b>		DATE SIGNED <b>1/29/60</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Benjamin S. Miller, M.D.</b>		<b>Mt. Rainier, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 30, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St John's Cemetery</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 1 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01119

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>7 yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. STREET ADDRESS <b>5400 Nash Street</b>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Elsworth</b> Last <b>Williams</b>				4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-13-64</b>		9. AGE (In years last birthday) <b>95</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Janitor</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Williams</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Addison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hattie Jett; 2323 17th St. N.W. Wash., D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exhaustion</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Maloney</b>				ADDRESS <b>30 H Street, N.E.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 22 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John A. Smith		SEX Male	
AGE 45		DATE OF BIRTH Jan. 15, 1880	
PLACE OF BIRTH Boston, Mass.		OCCUPATION Clerk	
MARITAL STATUS Married		DATE OF MARRIAGE Dec. 10, 1905	
NAME OF SPOUSE Mary A. Smith		NAME OF DECEASED'S FATHER William A. Smith	
NAME OF DECEASED'S MOTHER Sarah A. Smith		DISTRICT OF DECEASED District of Columbia	
DATE OF DEATH Jan. 10, 1920		TIME OF DEATH 10:30 A.M.	
PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		MEDICAL OPINION The deceased died of natural causes, the result of a long-standing heart disease.	
SIGNATURE OF MEDICAL EXAMINER Dr. J. H. Jones		SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary A. Smith	
OFFICIAL SEAL OF MEDICAL EXAMINER		OFFICIAL SEAL OF DECEASED'S NEAREST RELATIVE	

RECEIVED  
 JAN 15 1920  
 BOSTON, MASS.



## 1123 CERTIFICATE OF DEATH

01120

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>16.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HCCOKEEK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X HCCOKEEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>P.O. Box 9</u>				d. STREET ADDRESS <u>1 P.O. Box 9</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>IRENE</u> Middle <u>YERRY</u> Last <u>YERRY</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 24, 1892</u>	
9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Law</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>CLINTON HOLDEN</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. HORN BECK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>126-09-411</u>		17. INFORMANT <u>MRS. ROBT. MURPHY</u>		Address <u>GRAND DAUGHTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary thrombosis</u> DUE TO (b) <u>General arteriosclerosis</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>  <u>years</u>  <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left hemiplegia since 3-25-58</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 23rd, 1958</u> , to <u>Jan. 15th, 1960</u> , that I last saw the deceased alive on <u>January 15th, 1960</u> , and that death occurred at <u>12:30 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Accokeek, Md.</u> DATE SIGNED <u>January 15th, 60</u> ACTUAL SIGNATURE <u>Paul Chen, M.D.</u> PHYSICIAN'S NAME (Type) <u>PAUL CHEN, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-18-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY HIDE PARK</u>		22d. LOCATION (City, town, or county) (State) <u>POUGHKEEPSIE N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi Funeral Home 816 H St. N.E. Wash DC</u>				24a. REC'D BY REGISTRAR <u>JAN 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File No. 100-100

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>Jan 15 1945</i>		5. PLACE OF DEATH <i>Home</i>	
6. OCCUPATION <i>Teacher</i>		7. MARITAL STATUS <i>Married</i>		8. PLACE OF BIRTH <i>Maryland</i>		9. DATE OF BIRTH <i>Jan 15 1900</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. MEDICAL HISTORY <i>None</i>		12. PRESENT ILLNESS <i>None</i>		13. TIME OF DEATH <i>10:00 AM</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF PHYSICIAN <i>John Doe</i>		17. SIGNATURE OF CLERK <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>		19. SIGNATURE OF JUDGE <i>John Doe</i>		20. SIGNATURE OF SHERIFF <i>John Doe</i>	
21. SIGNATURE OF CORONER <i>John Doe</i>		22. SIGNATURE OF DECEASED'S NEAREST RELATIVE <i>John Doe</i>		23. SIGNATURE OF DECEASED'S NEXT OF KIN <i>John Doe</i>		24. SIGNATURE OF DECEASED'S ATTORNEY <i>John Doe</i>		25. SIGNATURE OF DECEASED'S MINISTER <i>John Doe</i>	
26. SIGNATURE OF DECEASED'S CHURCH <i>John Doe</i>		27. SIGNATURE OF DECEASED'S FUNERAL HOME <i>John Doe</i>		28. SIGNATURE OF DECEASED'S BURIAL PLACE <i>John Doe</i>		29. SIGNATURE OF DECEASED'S CEMETERY <i>John Doe</i>		30. SIGNATURE OF DECEASED'S INTERMENT <i>John Doe</i>	
31. SIGNATURE OF DECEASED'S CREMATION <i>John Doe</i>		32. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		33. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		34. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		35. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
36. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		37. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		38. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		39. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		40. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
41. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		42. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		43. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		44. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		45. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
46. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		47. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		48. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		49. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		50. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
51. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		52. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		53. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		54. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		55. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
56. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		57. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		58. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		59. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		60. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
61. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		62. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		63. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		64. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		65. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
66. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		67. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		68. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		69. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		70. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
71. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		72. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		73. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		74. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		75. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
76. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		77. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		78. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		79. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		80. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
81. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		82. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		83. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		84. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		85. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
86. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		87. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		88. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		89. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		90. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
91. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		92. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		93. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		94. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		95. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	
96. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		97. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		98. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		99. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>		100. SIGNATURE OF DECEASED'S REINTERMENT <i>John Doe</i>	

## 1059 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>11 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, 27</b> d. STREET ADDRESS <b>7137 Whitehouse Rd.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Young</b> Last <b>Young</b> 4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>1960</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Jan. 5-60</b> 9. AGE (In years last birthday) <b>11</b> yrs. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b> 11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Francis Chapman</b>		14. MOTHER'S MAIDEN NAME <b>Claudia Virginia Young</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
INFORMANT		Address	

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

762.5 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

*detected*

*Prematurity*

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. p. m.  
1920d. INJURY OCCURRED  
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from **Jan. 5**, 19**60**, to **Jan. 15**, 19**60**, that I last saw the deceased alive on **Jan 15**, 19**60**, and that death occurred at **8:30P.M.**, from the causes and on the date stated above.

ACTUAL SIGNATURE

*John W. Perkins*

ADDRESS (Street, city or town, state)

M.D. **5301 Hamilton St., Hyattsville, Md.** DATE SIGNED **1/17/60**

PHYSICIAN'S NAME (Type)

**Dr. John Perkins, M.D.****5301 Hamilton St., Hyattsville, Md.**

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	22b. DATE THEREOF <b>1/27/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>	22d. LOCATION (City, town, or county) (State) <b>Hyattsville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry W. Penn, Jr.</i>		24a. REC'D BY REGISTRAR <b>Harry W. Penn, Jr., Administrator.</b>	24b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077222XV2



# 1 death: Page 4 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) ISM 10/57

Item 8 FilmG255 2-3-60 et

## 1061 CERTIFICATE OF DEATH

01122

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DISTRICT Hts.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DISTRICT HEIGHTS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>17809 NIMITZ DRIVE</u>		d. STREET ADDRESS <u>17809 NIMITZ DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Isabella Brown Young</u>		4. DATE OF DEATH <u>Jan. 28, 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 2nd 1871</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES GALLACHER</u>		14. MOTHER'S MAIDEN NAME <u>(UNKNOWN) BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>THOMAS R. YOUNG-17809 NIMITZ DR, MD</u>		Address <u>DISTRICT Hts</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac Cerebro-Vasc. Accident</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 26, 1960</u> to <u>Jan 28, 1960</u> , that I last saw the deceased alive on <u>Jan. 26, 1960</u> , and that death occurred at <u>8 A.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>DISTRICT Hts</u> DATE SIGNED <u>1-28-60</u>			
ACTUAL SIGNATURE <u>Bernard Katzen</u> M.D. <u>3550-Min. Ave. S.E. Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>BERNARD KATZEN M.D.</u> <u>3550-Min. Ave. S.E. Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/30/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WASH NATL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND MD. 6060, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS Co - WASHINGTON, DC</u>		24a. REC'D BY REGISTRAR <u>FEB 1 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

Form 10-1-14

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1870		BALTIMORE		BALTIMORE		BALTIMORE		MD	
MARRIAGE		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
MARRIED		1895		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		MD	
EDUCATION		SCHOOL		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		BUSINESS		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
BUSINESS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		HEART DISEASE		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
HEART DISEASE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MANNER OF DEATH		NATURAL		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
NATURAL		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		1915		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
1915		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
PLACE OF DEATH		HOME		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
HOME		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		J. H. HARRIS		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
J. H. HARRIS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNATURE OF REGISTRAR		J. H. HARRIS		CITY		COUNTY		STATE		CITY		COUNTY		STATE		CITY	
J. H. HARRIS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

NOTICE: This certificate is valid only when filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.



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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G254 1-18-60 et

## CERTIFICATE OF DEATH

01123

Reg. Dist. No.

1124

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill, Md.</b>				c. LENGTH OF STAY IN 1b <b>4 Years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>14 Oxon Hill, Maryland</b>				d. STREET ADDRESS <b>5669- Bock Terrace S.E.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5009- Bock Terrace S.E.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARGARET</b> First <b>ELENA</b> Middle <b>ZELL</b> Last				4. DATE OF DEATH <b>Jan.</b> Month <b>10th</b> Day <b>19</b> Year <b>60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 8th 1912</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Albert C. Scott</b>				14. MOTHER'S MAIDEN NAME <b>Katie C. Huhn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Joseph A. Zell Same as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Duct cell carcinoma of Breast</b> DUE TO (c) <b>3 mos</b> <b>3 yrs</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> , 19, to <b>1/10</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/10</b> , 19 <b>60</b> , and that death occurred at <b>10:15</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frederick Y. Donn</b>				ADDRESS (Street, city or town, state) <b>1835 - Eye Street N.W.</b>			
PHYSICIAN'S NAME (Type) <b>FREDERICK Y. DONN</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 13-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ammons Bros</b> ADDRESS <b>1661- Good Hope Rd. S.E. Washington 20, D.C.</b>				24a. REC'D BY REGISTRAR <b>JAN 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

11163

MULTIPLY STATE OF MINNESOTA DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

11164

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]  
EDUCATION: [illegible]  
RELIGION: [illegible]  
MARRIAGE: [illegible]  
SPOUSE: [illegible]  
CHILDREN: [illegible]  
PARENTS: [illegible]  
SIBLINGS: [illegible]  
PREVIOUS ILLNESSES: [illegible]  
PRESENT ILLNESS: [illegible]  
DATE OF ONSET: [illegible]  
DATE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
DATE OF BURIAL: [illegible]  
PLACE OF BURIAL: [illegible]

*[Faint handwritten notes and signatures, possibly including a date like 1/15/1918]*